# EVALUATION REPORT PHASE 1 Feb - Jun 1976

# EPSDT Demonstration in an Urban Setting Dallas, Texas






Prepared by
Health Services Research Institute
The University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78284

Prepared under a grant awarded by the Social and Rehabilitation Service, DHEW

# FIRST EVALUATION REPORT

SRS/DHEW Demonstration Project

## EPSDT IN AN URBAN SETTING - DALLAS, TEXAS

Period Covered - February 1, 1976 - June 30, 1976

Health Services Research Institute
The University of Texas Health Science Center at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78284

Harold D. Dickson, Ph.D. - Institute Deputy Director (Consultant)
Arthur E. Britt, M.A. - Principal Evaluator
Stanley Marett, M.C.S. - Assistant Evaluator
Nancy Barbas, M.A. - Assistant Evaluator (On-site Coordinator)
Laurilynn McGill, B.A. - Assistant Evaluator

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SUMMARY

1. The Dallas project--EPSDT in an Urban Setting - Dallas, Texas--was approved and funded by SRS under Section 1115 of the Social Security Act in July, 1975. The period between July, 1975 and February, 1976, when the project became active experimentally, was devoted to "start-up" activities.

This is the first evaluation report covering certain aspects of the start-up activity and more fully the experimental period of February 2, 1976 to June 30, 1976 (five months). Four other reports are programmed at six month intervals each reflecting cumulative data from the project's inception, i.e., 11 months, 17 months, 23 months and 30 months (the final report).

2. The major experimental (demonstration) thrust of this project in this period of activity (February - June) was to develop and test innovative, effective and inexpensive methods of case finding (outreach) and case monitoring (follow-up) for the EPSDT program in an urban environment.

3. The limited experimental time period covered by this first report, the limited numbers involved in certain aspects of the testing (limited sample) in this time period, and organizational difficulties in identifying or delineating program eligibles and activities between the project and the inplace (ongoing) activities restrict the general programmatic utilization of the data contained in this report.

4. As a consequence, this report, in addition to reporting certain programmed though limited data, is heavily weighted in the following directions:

a. Explanation of research design data collection, and evaluation methodology.

b. Discussion of the sequence of events in interrelationship between the project and the political/government environment in which it initiated and conducted operations and the impact of these events on the project design, data collection and programmed evaluation.

Notwithstanding extensive efforts to "control" a research design and maintain a "purity" of data, distortions in data, which relate in many instances to events beyond a project's control, may well be typical of research designs imposed on "ongoing" service delivery activities. It is as an example of these circumstances that this report may have more value than the preliminary statistical data it contains.

5. The full cycle data system developed for this project <u>represents completed actions</u> in the case finding subsystem only for February and March, 1976 and a limited number of completed actions for the case monitoring subsystem (problem completions, case completions, etc.) The next report (No. 2) will contain a much more substantive data base. Nevertheless, the data system which tracks each EPSDT action to a resolution or termination is demonstrating an

exciting potential. Following is a schematic of a "track" of 244 family contacts, representing 649 children, made in the Dallas project in February and March, 1976 (first two months of activity), through "appointments to screening", to "show for screening", to "problems found" and to "problem resolution or termination". Although these preliminary data are too inadequate to be representative of the operation for evaluation, they are indicative of the type data that will be forthcoming from this project in the next and subsequent reports.

6. In a tentative sense, this tracking schema indicates that two weak points in this project system are the "shows for screen" (59% of those appointed) and the "problems found" (13% of those screened). These are discussed in detail in the accompanying report.

7. The eligible population penetration rate (shows for screen of eligibles) based upon February and March experience and then projected for annualization (12 months) reflects as follows (discussed in detail in the accompanying report):

(Projected to January 31, 1977)

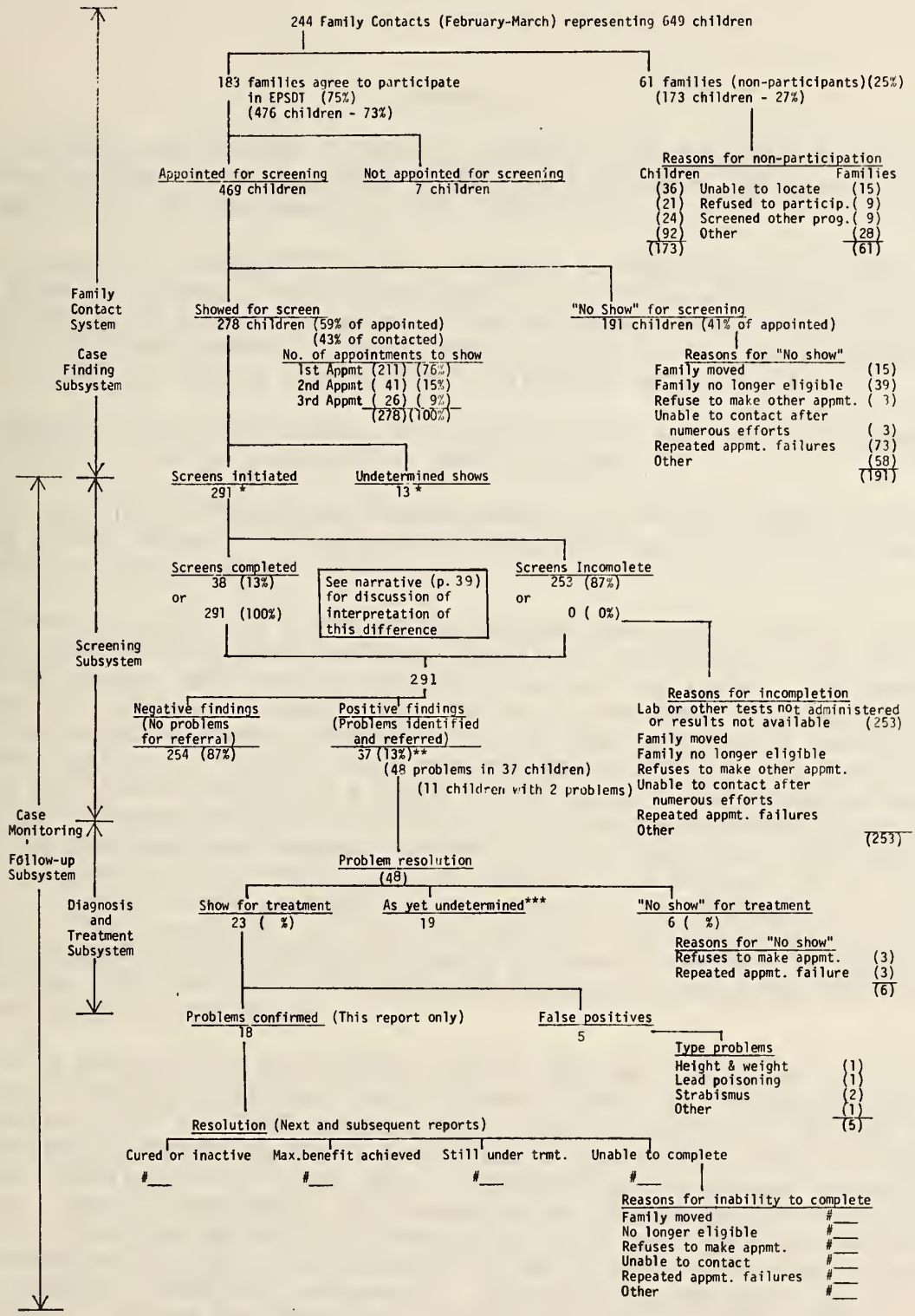
| | |
|---|---|
| Overall Project | 39% |
| Sector A | 38% |
| B | 24% |
| C | 55% |
| D | 38% |
| Age groups | |
| 0 - 5 | 40% |
| 6 - 12 | 43% |
| 13 - 18 | 35% |
| 19 - 20 | 23% |

Most significantly, it is projected that the contact rate for Sector C could reach close to 100% contact of all eligibles within 12 months of activity. This will be one of the first locations in any project (or program) where close to 100% of the eligibles will have been contacted. The projected "show for screen" (penetration) rate of only 55% of this projected fully contacted population will be closely scrutinized and variations of technique proposed for testing to ascertain if this is the maximum achievement of the full time face-to-face/in-the-home case finding technique.

The 35% penetration of the teenage group is considered uniquely high because of the generally experienced resistance of this group to associate with a "children's" program.

8. It would appear that the "show for treatment" rate for problems found in screening will be in the area of 75% when the data is full-cycled for this period.

A "TRACK" THROUGH THE EPSDT PROGRAM OF 244 FAMILY CONTACTS
MADE IN FEBRUARY/MARCH, 1976
DALLAS PROJECT




*As described in the narrative, a "linkage system" between the family contact system and the screening system is under development and, when complete, a complete "tracking" can be accomplished. At this point, there is a discrepancy of 13 "shows" between the two systems. In other words, case finders have reported 13 less screening appointments kept than screening sheets initiated at the screening site.

**See screening chapter for problem type delineation.

***In the next report, when full subsystem cycles will be in effect, all cases will be "show" or "no show". In this report "As yet undetermined" will ultimately be "show"/"no show", therefore, no percents are shown; they would be misrepresentative.

## PREFACE

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program was enacted into law as a section of Title XIX of the Social Security Act by the Social Security Amendments of 1967 (PL90-248).

Through this amendment Congress intended to require states to take aggressive steps to screen, diagnose and treat poor children with health problems. The Congress had been concerned about the variations from state to state in the rates of children treated for handicapping conditions and health problems that could ultimately lead to costly chronic illnesses and disability.

EPSDT, in the ideal sense, is intended to be a program for comprehensive preventive and health services for "poor" children.

It was then estimated that approximately ten million "poor" children (12% of the United States child population) throughout the United States would be eligible for the program.

Notwithstanding the intent of the program, the unique federal-state sharing of its responsibility still reflects significant variations in the degree to which the program has been implemented by the various states. The federal agency charged with program implementation, the Social and Rehabilitation Service, DHEW, has acted in several ways to bring the lower spectrum of variability to a minimum standard. First, it sponsored, and Congress enacted, a "penalty" provision to the law for failure of a state to meet certain basic program requirements for informing eligible clients, providing screening when requested, and providing treatment when needed. Secondly, it has provided significant technical assistance to the states through contracts and regional office staff. Thirdly, it has devoted considerable resources to: (1) evaluation and identification of "best practices" and "program barriers" for dissemination to the states and (2) conduct of demonstration projects to develop information systems and innovative, effective and cost beneficial methods for providing EPSDT services for assistance to the states.

It is primarily in this latter context that the the Health Services Research Institute, University of Texas Health Science Center at San Antonio has been involved with SRS and EPSDT programs since 1972*. Initially, SRS had funded four separate projects in Contra Costa County, California; Cuba, New Mexico; San Antonio, Texas; and Washington, D.C. to explore various aspects of the EPSDT program. Shortly thereafter, SRS requested the HSRI to establish a common data base for these four projects in order to evaluate their programs and provide recommendations to SRS concerning utilization of findings in a multitude of state programs (technical assistance). This activity has been, and is scheduled to continue, through the phase-out of these projects in 1975 - 1977.

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*The Health Services Research Institute (HSRI) was originally established in 1972 as a component of The University of Texas Health Science Center at San

(Continued next page)

In 1975 the directive staff of the Office of Planning, Research and Evaluation (OPRE) SRS, prescribed a more formal and structured approach to research and demonstration. In this context, HSRI developed a comprehensive research design with a common data base for interrelated research projects (see EPSDT Demonstration Model Evaluation Handbook) to be undertaken in several urban sites of high eligible population density. These projects were to be predicated upon maximizing the use of the inbeing health care delivery systems, focusing on new and innovative techniques for getting poor children into the health system (case finding/outreach) and, when appropriate, holding them there until their health needs were met (case monitoring: screen completions/treatment initiation/treatment completion). Three proposals (projects) were funded by SRS in FY 76 under this "grand design", i.e., New York City, N.Y.; Miami, Florida; and Dallas, Texas, for the first year of three year projects. Intermeshed in major personnel changes in the OPRE/SRS directive staff in 1975-76, however, were further changes in research concepts and priorities, with less emphasis on "pure" research design. As a consequence, the three projects became "independent" of each other, with the Dallas project being the only one remaining within the original context for evaluation by the HSRI. Its major thrust continued unmodified as the "development of innovative, effective, and cost beneficial methods of case finding and case monitoring for the EPSDT program in an urban environment."

The Dallas project--EPSDT in an Urban Setting - Dallas, Texas--was approved and funded by SRS under Section 1115 of the Social Security Act in July, 1975. It initiated methodological variations in February, 1976. It was refunded for continuation in July, 1976 with some redirection toward greater emphasis on reflecting the current programmatic informational needs of the Medical Services

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Antonio to serve as a Regional Research Institute of the Social and Rehabilitation Service, DHEW to provide consultation and assistance to the five-state DHEW Region VI.

The primary thrust of the Institute was to conduct research to improve the quality and quantity of health programs for the indigent. Though subsequent relationships with SRS diminished and then terminated the Regional Institute role and refocused its activities toward assistance to the central office in Washington and evaluation of the EPSDT program in the national context, the major concentration of the Institute remains unchanged and includes projects in family planning, aging, health manpower and child health (particularly in the area of developmental and emotional assessment and treatment).

The Health Services Research Institute is a team of multidisciplined researchers with individuals trained in economics, medical sociology, psychology, computer science, health management and manpower, and special education. The Institute's association with the University of Texas Health Science Center at San Antonio, which includes medical, dental, nursing and graduate schools, gives staff members ready access to professional consultation in many fields.

Dr. Harry Martin and Dr. Harold Dickson, both members of the medical school faculty, are respectively Director and Deputy Director of the Institute.

Administration, SRS; e.g., the older child, the role of the school, and interagency collaboration.

In terms of the current report requirements stipulated by SRS, five evaluation reports are projected for the project over the three years of its expected duration, as follows:

| Report No. | Period Covered | Due Date |
|---|---|---|
| 1 | Feb. 1, 1976 - June 30, 1976 | October 15, 1976 (This report) |
| 2 | Feb. 1, 1976 - Dec. 31, 1976 | April 15, 1977 |
| 3 | Feb. 1, 1976 - June 30, 1977 | October 15, 1977 |
| 4 | Feb. 1, 1976 - Dec. 31, 1977 | April 15, 1978 |
| 5 (Final) | Feb. 1, 1976 - June 30, 1978 | December 31, 1978 |

As a format in general, the preface, which depicts the overall national federal environment in which this project was conceived and approved; the introduction chapter, which depicts the immediate (State and local) environment and needs for the project as well as its initial design and structure; and the data system chapter, which depicts the design of data input (forms, computer processing, and the data system hardware) will be similar for each report. The chapters on case finding, case monitoring, and costs depicting the impact of the variables will reflect the changes from report period to report period.

# INTRODUCTION

## The National Scene

The concentration of SRS demonstration activities on urban centers in 1975, in which time frame the Dallas project was conceptualized, was determined by the fact that 64% of all program eligible children in the United States were located in 14 of these centers. Not only was client participation in the EPSDT program minimal, but no governmental agency had as yet adopted the procedures to determine if children requiring treatment received it. A further element of consideration in the selection of major urban sites was the premise that if the program was to work, it must prove itself in the slums of New York, Chicago, Los Angeles, Dallas, etc.

## The Texas Scene

As previously indicated, the major thrust of the Dallas project was to maximally utilize the inbeing health care system in the EPSDT program by placing the project emphasis on innovative case finding techniques that would effectively induce client participation and, if children were found to have health problems through the screening process, assure, through effective case monitoring techniques, that these children were appropriately treated.

The Medical Services Specialties Division of the Texas State Department of Public Welfare developed the coordinative base for the project throughout FY 75.

The Department of Public Welfare, with overall EPSDT program responsibility, contracts with the State Department of Health Resources to " . . . provide for the early and periodic medical screening for purpose of referral for diagnosis and treatment of all eligible individuals . . . to ascertain physical and mental defects. . . .The Texas State Department of Health further agrees to refer back to the Department of Public Welfare those eligible individuals who are screened in accordance with this provision and are found to be in need of further diagnosis and medical care." The State of Texas is unique among the states in that the Department of Public Welfare contracts separately with the State Department of Health Resources for dental services for program (Title XIX) eligible children. De facto, there are two separate programs--the medical EPSDT program and the Title XIX dental program. This fact, in itself, has many ramifications for the Dallas project, as will be addressed in these evaluations over the duration of the project.

## The Dallas Area and the Project Site

Preliminary considerations were given by the State to placing the project in Houston, but later considerations settled on Dallas because of the local enthusiasm in both health and welfare agencies for the project. There were approximately 300,000 children in Texas eligible for the EPSDT program, with roughly 12% (36,000) located in Dallas County. In July, 1975, following SRS

approval of the Texas application, Special Projects Bureau of The State Department of Public Welfare was assigned responsibility for the conduct of the project. It, in conjunction with the Medical Services Specialties Division of the Department and the Dallas Regional Office of the Department of Public Welfare, devised a plan to locate the project in two of the five geographic areas for which the Dallas area had been divided for the overall EPSDT program. These two areas were covered by two DPW units for EPSDT and other Department of Public Welfare programs, e.g., dental Title XIX program, family planning, etc. These two areas were to be further subdivided into a total of four areas (see following map) for research/demonstration purposes with identification and eligible population, as follows:

SCHEMA - Sectors, Associated Zip Code Areas, Program Eligibles as Related to Total Population in Sector, and Supportive EPSDT Screening Clinics

| Sector | Zip Code Area | EPSDT Program Eligibles (by Sector) | % of Sector Population EPSDT Eligible | Correlated EPSDT City Screening Clinics |
|---|---|---|---|---|
| A | 75203, 75108 | 8,454 | 7% | Lions Club Clinic |
| B | 75216, 75224 | | 15% | Harris Center |
| C | 75215 | 4,554 | 17.6% | Martin L. King; Spring |
| D | 75210, 75223 | 3,573 | 23.4% | Martin L. King; Spring |
| Total | | 16,581* | | |

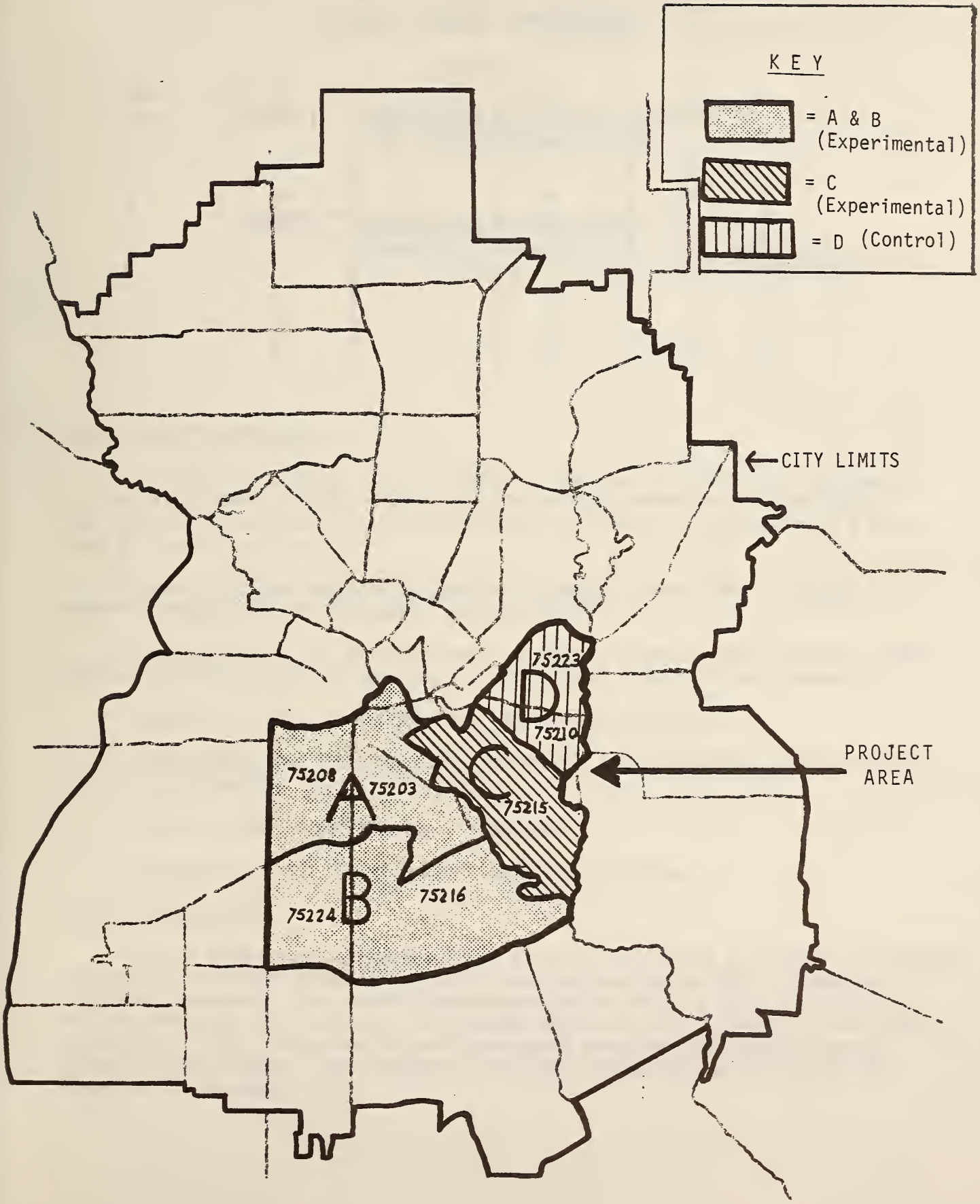
*Generally 95% black; 3% Spanish surname; 2% Anglo

Sector A, B, and C were to be utilized for experimental variation, and D as control sector (representing the "ongoing" activity).

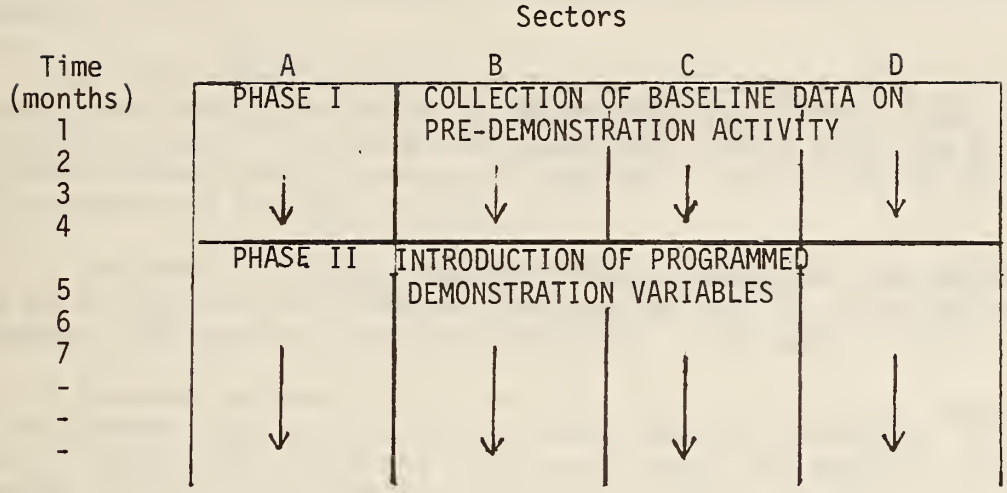
## The First Year's Planned Phasing

In the initial year activities, time was planned to be utilized as follows, with month (1) intended to be any month following project approval (July) in which the project could reach such a state of case finding and case monitoring organization as to begin data collection.

CITY OF DALLAS AND EPSDT PROJECT AREAS



PROJECT PLANNED TIME PHASING




## The Actual Time Phasing

As it occurred, month (1) was February, 1976, which left only five months in the fiscal year to collect data and initiate the demonstration variables. The time lag from July, 1975 through February, 1976 was attributable to a multitude of factors such as

- rewrite of the proposal by Special Projects Bureau, DPW, including revised budgets and its subsequent approval by SRS

- preparation of job descriptions in support of the revised proposal; then review, classification and approval by appropriate State personnel agencies

- posting of jobs, announcements, interviews, selection

- development and coordination of forms for data collection; then procurement and pre-testing

- training and indoctrination of personnel

- coordination and planning with the ongoing program

## Start-up Activities

Since a determination had been made to hire and process all project personnel through the standard personnel structure and systems rather than as temporary short-term personnel for research/demonstration purposes, a great deal of time was expended for this purpose. The project director, Ms. Lucy Martin, was hired in October, 1975. Other key project management personnel and administration workers (case finders, case monitors, etc.) were hired during the period of November to December, 1975.

The HSRI on-site project and data coordinator, Ms. Nancy Barbas, was placed under contract by The University of Texas Health Science Center effective December 1, 1975.

HSRI and project management personnel conducted a forms pre-test in the project area during the period of December 10 - 17, 1975. Final changes were accordingly made in the forms and procurement action initiated by Special Projects Bureau during December and January. The delivery of the final printings was accomplished by late February, 1976.

A forty-hour Training Program for Case Finders and Case Monitors in EPSDT and an accompanying Workbook was developed by HSRI in the time from August to November, 1975 and was furnished the project in November, 1975.

A two-week training course was conducted by the project managerial staff in conjunction with the Dallas DPW Family Services Educational Director, Ms. Ethel B. Crear, for all project personnel during the period of January 12 through 23, 1976. This 80-hour course included instruction in the EPSDT program, preventive health care, research and research design, data collection, (concept, forms, explanation), services provided by DPW, child development, health problems of children, personnel policies, the Title XIX dental program, community resources, overview of Medicare and Medicaid, use of volunteers, case finding and case monitoring (to include extensive role playing exercises), EPSDT health screening, etc.

The appropriateness and basic necessity for all this "start-up" activity leads to the conclusion that any new project of this magnitude should include a "start-up" period of, at the absolute minimum, three months and preferably six months.

## Alterations in Time Phasing

Confronted with the unalterable passage of time consuming so many months of the first year's project activity, the project director decided to by-pass Phase I (the four-month period for collection of base line data) and initiate Phase II (introduction of programmed demonstration variables) on February 2, 1976. HSRI then supported this action in modifying the research design to utilize the "control sector" as representative of the entire project area (the base).

## The Programmed Research Variables (First Year's Activities)

### Case Finding

The research/demonstration variables contained in the proposal for introduction at this point to assess their impact on population penetration (as measured by shows for screen) were as follows:

- Use of full time case aides as EPSDT case finders employing primarily a

face-to-face, in-the-home, contact technique.

- Use of an incentive payment to mothers ($3.00 transportation reimbursement) to bring their children to screening.

Case Monitoring

The research/demonstration variables contained in the proposal for introduction at this point to assess their impact on children who had showed for screening in terms of screening completions, problem completions, case completions, and immunization completions were as follows:

- Full time EPSDT case monitors of varying skills, i.e., Public Welfare Workers, Community Service Aides, and Public Health Nurses.

Diagrammatically, this can be depicted as follows:

RELATIONSHIP OF VARIABLES, AREA, POPULATION AND CLINICS IN THE PROJECT

| | Sectors | | | |
|---|---|---|---|---|
| | A (A-J) | B (K-Z) | C | D |
| Zip codes | 03, 08, 16, 24 | 03, 08, 16, 24 | 15 | 10, 23 |
| Clients | 4,227 | 4,227 | 4,554 | 3,573 |
| DPW Units | I[1] | I | II[2] | II |
| Associated EPSDT Screening Clinics | Harris Center Lion's Club Clinic | Harris Center Lion's Club Clinic | Martin L. King Ctr Spring Clin. | Martin L. King Ctr. Spring Clinic |
| Case Finding Technique | Incentive (Transportation) payments ($3.) | Incentive (Transportation) payments ($3.) | Aides (Full time/ face-to-face contact) | Control |
| Case Monitoring Technique | Public Welfare Worker | Community Service Aide | Public Health Nurse | Control |

[1]Under the supervision of Ms. Mary Powell

[2]Under the supervision of Ms. Rose Schultz

The Procedures Used for EPSDT by "Ongoing" in the Dallas Area

The ongoing activity prevailing in the Dallas area in regard to routine EPSDT case finding and case monitoring was generally as follows:

Six Family Service Units of the Department of Public Welfare in Dallas, comprising 50 workers with multiple program responsibilities, were doing EPSDT case finding and case monitoring. The method of outreach (case finding) and/or monitoring chosen by each unit was generally as prescribed by the unit supervisor. Worker effort commonly consisted of sending letters to eligible families introducing the program and subsequently arranging screening appointments by phone for those clients who responded affirmatively to the letter. They also assisted in providing transportation to the clinic with occasional home visits. A minimal amount of time was available for follow-up to treatment of children with problems found in screening.

Prior to the project starting in the Dallas area, it is estimated* that these efforts utilized ongoing case worker time, as follows:

Case finding
- 40% letter preparation and dispatch
- 30% phone follow-up
- 10% transportation for clients
- 10% home visits

Case monitoring
- 10% follow-up (case monitoring)

Preliminary negotiations by HSRI and project personnel with representatives of the Texas State Departments of Public Welfare and Health concerning forms to be utilized in the project area for data collection resulted in a dictum that newly proposed DPW, EPSDT Medical Referral (TDHR-DP 402) and Medical Referral Supplement (402-S) forms be tested in the Dallas area prior to statewide adoption. As a consequence of this action concurrently with the project initiation (February 1, 1976), not only was a new data collection form and case monitoring technique used in the project, but it was also introduced throughout the Dallas area in the ongoing EPSDT activities. This new form and accompanying procedures of necessity compelled increased ongoing attention toward case monitoring, thereby automatically reducing the differences in these activities between ongoing and the project than had been projected in the original project proposal to the Social and Rehabilitation Service, DHEW. As a consequence, ongoing worker activity during the period of February through June, 1976 (this report period) developed into the following (and current) estimated commitment of time:

Case finding
- 30% letter preparation and dispatch
- 20% phone follow-up
- 10% transportation for clients
- 10% home visits

Case monitoring
- 30% follow-up (case monitoring)

As data is collected on worker activity in the control sector from July, 1976 onward, worker time commitments will be appropriately documented.

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*Without Phase I to establish a data base of ongoing pre-project EPSDT activity, this could not be documented.

## The Cost and Effectiveness Comparisons

The project effort was, in the main, to endeavor to ascertain (1) whether the full time EPSDT case finders doing almost exclusively in-the-home, face-to-face contacts, and the payment of an incentive transportation fee to clients could demonstrate significantly improved and cost beneficial rates of "shows for screen" of the eligible population (penetration rate) in respect to each other (each technique) and over that being accomplished by the ongoing activity as represented by Sector D--the control; and (2) whether full time case monitors of varying skills using essentially the same techniques could achieve significantly increased (and cost beneficial) rates of treatment and screening completions in respect to each other and over that being accomplished by the ongoing, as represented by Sector D--the control. Correlated objectives involved were to determine task performance standards (work level yardsticks) for case finders and the lowest skill level at which effective case monitoring related rates could be achieved (screen completions, problem completions, etc.)

## Health Screening in Dallas

The health screening process itself, in Dallas, is carried out under subcontract by the City of Dallas Department of Health. A nine member Health Department screening team, headed by registered nurse screeners, under the direction of Nancy White, M.D., works at a different location (a series of scheduled fixed sites) within the city each weekday. As previously indicated, four of these sites (Harris Center, Martin Luther King Center, Spring Clinic, and the Lions Club Clinic) are located in and support the project area eligible population.

Pre-project conferences between the State Department of Public Welfare (EPSDT Program Coordinator, Mr. Ray Kruger) and the State Department of Health Resources (Dr. William Brumage) had elicited a verbal understanding that, if the project generated a requirement (as reflected in an increasing rate of shows for screen) for increased capacity, the Health Department would provide such capacity. In the same vein but another context, it was agreed that screening capacity must not be allowed to constrain the case finding effort as this would distort results in the case finding area.

## The Project's First Year Funding

The first year's funding (July 1, 1975 to June 30, 1976), including evaluation for the project, was approved by SRS for a total of $295,915.

## The Project's Initial Staffing and Organization

The project staff was generally configured as follows:

| | |
|---|---|
| Project management | 11 |
| Demonstration workers | 10 |
| | 21 |

The position classifications associated with these authorized manpower spaces were as follows:

Project Management

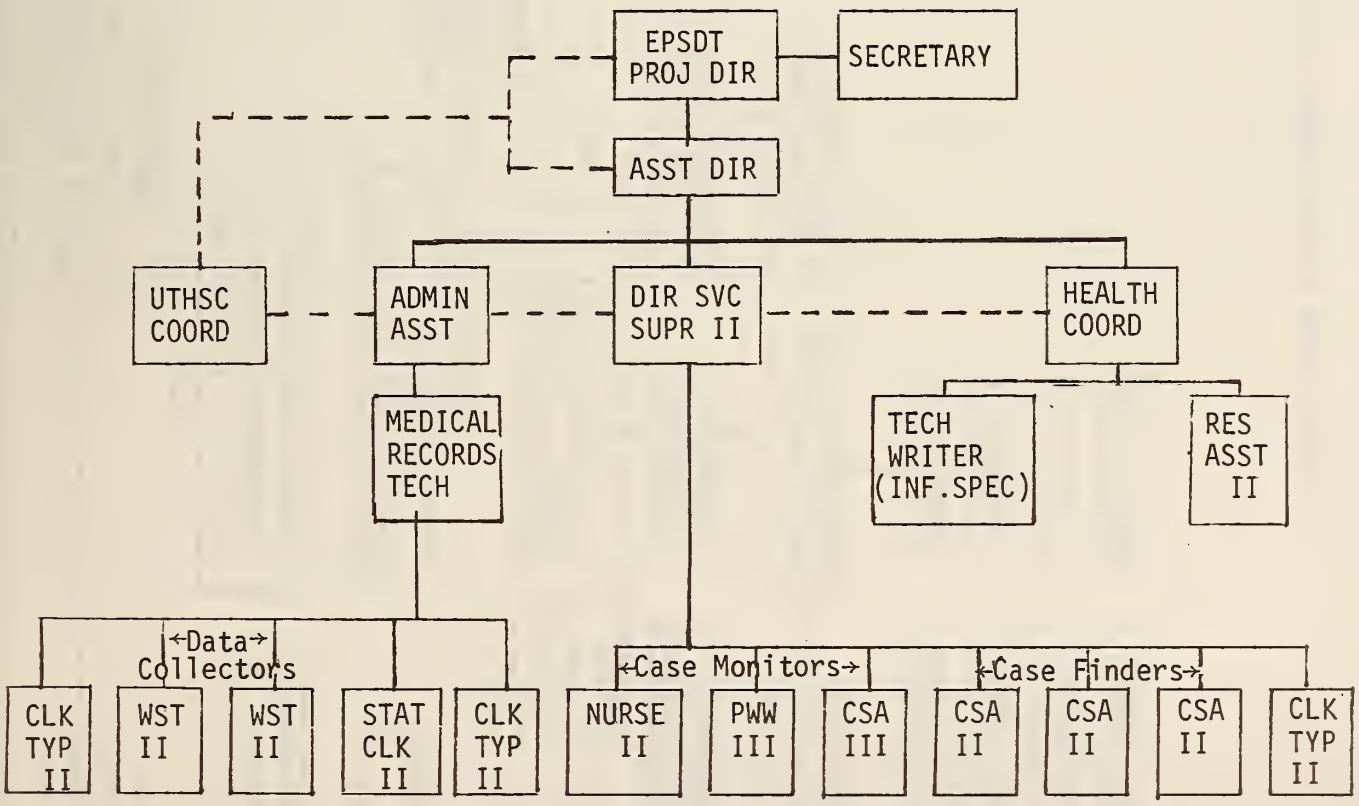
1. Project Director
2. Assistant Director
3. Secretary
4. Administrative Assistant
5. Health Coordinator
6. Information Specialist
7. Research Assistant
8. Medical Record Technician
9. Statistical Clerk
10 - 11. Clerk-typists (2)

Demonstration Workers

1. Project Worker Supervisor
2 - 3. Data Collectors (2)
4. Case Monitor (R.N.)
5. Case Monitor (P.W.W. III)
6. Case Monitor (C.S.A. III)
7, 8, 9. Case Finders (3)
10. Clerk-typist

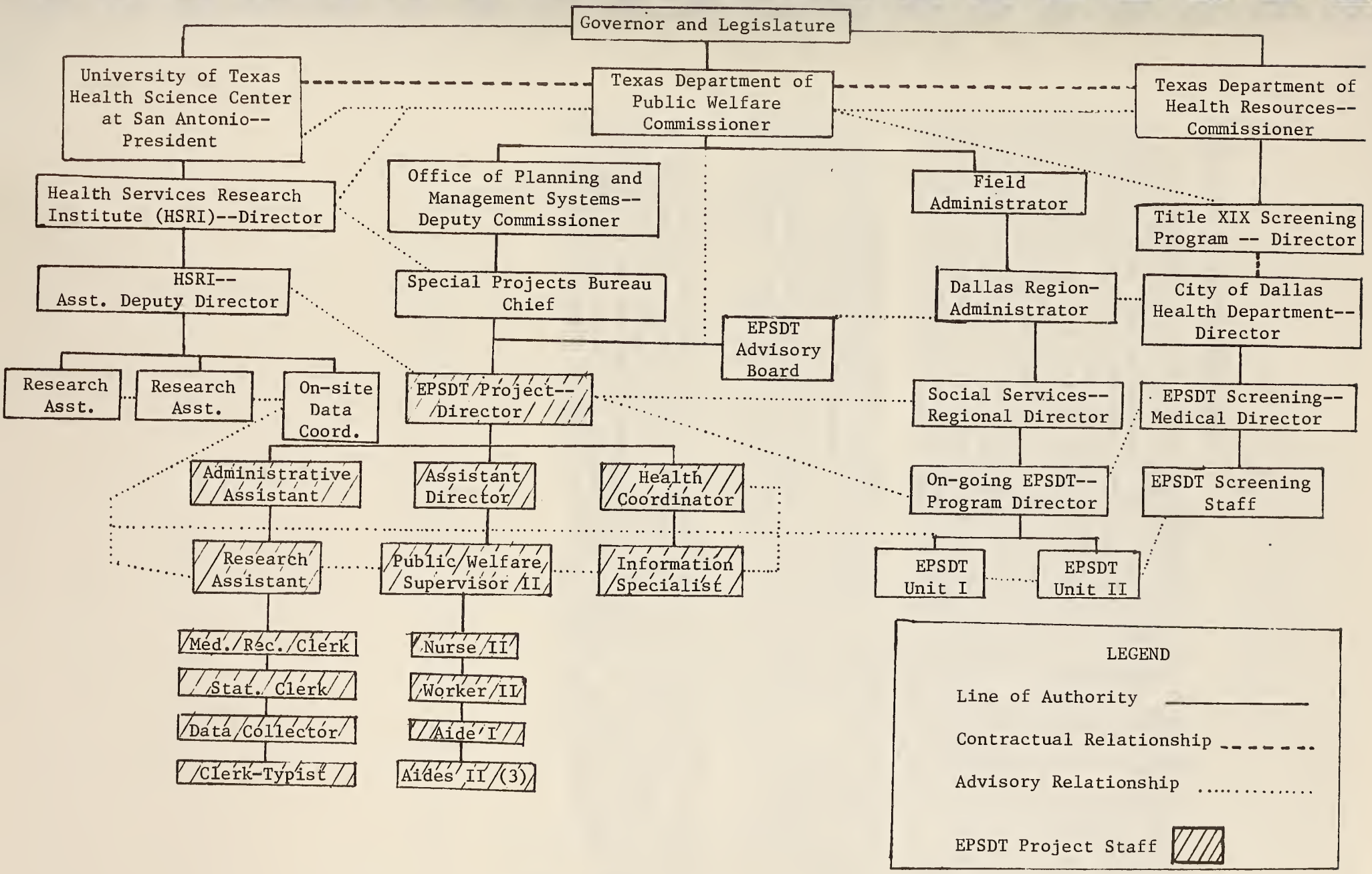
Organizationally, these personnel were structured as follows, to accomplish the project mission:

PROJECT INTERNAL ORGANIZATION




The Project and Its External Relationships

The external relationship of the project to other State and local agencies, advisory groups, and the Health Services Research Institute are reflected on the following chart:




EPSDT/URBAN PROJECT ORGANIZATION CHART

Changes in First Year Variables

At a meeting held in Dallas at the project site on December 18, 1975 between the SRS Project Officer, the Project Director, and the Chief, Special Projects Bureau, the decision was made to eliminate the incentive payment (transportation) of $3.00 case finding variable intended to be implemented in Sectors A & B. The intent of this variable was to determine, primarily from a cost perspective, the rate of client participation that could be achieved by a nominal direct payment incentive to the client with an absolute minimum of structured supportive overhead as compared to the rate of client participation achieved by a structured organizational approach with its inherent overhead costs. This was the A/B vs C and D comparison (schema on page 6 ). It appears that this variable was considered to have severe adverse public relations potential in the Dallas area, with possible national level reverberations and, on this basis, was deleted by full agreement of the parties involved in the meeting.

At a subsequent meeting on January 6, 1976 with representatives of the Medical Services Specialties Division, TDPW (Mr. Ray Kruger), Special Projects Bureau of TDPW (Dr. Alton Ashworth), the Project Director, and HSRI representatives, discussion of substitution variables took place. The alternative considered was to use as case finders college students in undergraduate social work programs requiring field work experience as a component of their course requirements. This case finding variable was to be introduced in Sector B.

Discussion in this instance also revealed that normal public supported transportation was generally no longer available in the Dallas area for support of EPSDT activities as a result of State cost saving activities. Since the requirement of transportation for successful case finding in EPSDT is generally accepted, it was decided to demonstrate its impact on case finding by making it available in one sector as a project funded service. The case finding design at this point (January 6, 1976) for implementation was as follows:

PROJECT EXPERIMENTAL CONFIGURATION FOR CASE FINDING (JANUARY 1976)

Sectors

| | A (Experimental) | B (Experimental) | C (Experimental) | D (Control) |
|---|---|---|---|---|
| I | Case Finders | Case Finders | Case Finders | Case Finders |
| | Ongoing case workers (Standard technique) (Assigned group of eligibles) | Student case aides (Home visit; face-to-face contact) (Assigned group of eligibles) | Demonstration case aides (Home visit face-to-face contact) (Assigned group of eligibles) | Ongoing case workers (Standard techniques) (Assigned group of eligibles) |
| II | Transportation | Transportation | Transportation | Transportation |
| | Taxi transportation | None | None | None |
| III | Spec. Consideration | Spec. Consider. | Spec. Consider. | Spec. Consider. |
| | Ongoing caseworkers use project Family Contact Form | Student aides use project Family Contact Form | Case aides use project Family Contact Form | Ongoing case workers use project Family Contact Form |
| | Ongoing case workers make a special "pitch" on availability of taxi transportation to screening | Student aides are paid $3.00 for for each child they bring to screening | Case aides function as case finders under the same operating configuration as case workers in Sector D | Case workers function as case finders under the same operating configuration as case aides in Sector C |

Efforts to achieve a "taxi" contract in support of Sector A did not come to fruition. As a consequence, the "de facto" variable structure in case finding for the five months of this report period was:

PROJECT REVISED EXPERIMENTAL CONFIGURATION FOR CASE FINDING

| | A | B | C | D |
|---|---|---|---|---|
| Feb | Ongoing worker using normal techniques[1] | Student case finder | Demonstration case aides doing face-to-face contact | Ongoing workers using normal techniques[1] |
| Mar | ↓ | ↓ | ↓ | ↓ |
| Apr | | (Terminated) | | |
| May | | Ongoing workers using normal techniques | | |
| June[2] | ↓ | ↓ | ↓ | ↓ |

[1]30% letter contact; 20% telephone follow-up; 20% home visits and transportation; 30% case monitoring

[2]A new transportation contract was let on June 1, 1976 for the Dallas region as a whole. Therefore, effective that date, routine transportation support for Title XIX eligibles again became available.

The "de facto" schema represented a vast effort devoted to Control (Sectors A, D and two months of B) with only variable contrast represented by Sector C, and three months of Sector B.

The limitations of this approach were recognized and definitive actions taken to strengthen the design for the following year of the project, which will be addressed in the next evaluation report (No. 2).

The case monitoring pattern remained unaltered throughout the period, i.e.,

PROJECT EXPERIMENTAL CONFIGURATION FOR CASE MONITORING

| | A | B | C | D |
|---|---|---|---|---|
| Feb | Case Monitor PWW III | Case Monitor Community Aide | Case Monitor Registered Nurse | Control[1] |
| March | ↓ | ↓ | ↓ | ↓ |
| April | | | | |
| May | | | | |
| June | | | | |

[1]The ongoing activity representing minimal case monitoring activity (30% estimated)

<u>Changes in Organizational Relationships and Population Base (N) Affecting the First Year's Design</u>

The <u>major problem</u> confronting this project during its first year (this report period) was developing an acceptable and workable relationship with the ongoing program. The fact that a workable solution was not achieved until the very end of this period (to be implemented at the beginning of the second year) distorted the purity and adequacy of the data being collected for this report

in many areas of project activity. This will be identified in the chapter dealing with the data analysis of the case finding and case monitoring variables.

The fundamental problem in organizational relationship emerged from the fact that in the initial concept, the ongoing program personnel in the Dallas Region were to supervise the project. The Project Director was to report to the DPW Regional Director. In this context the first design envisioned components of the program (geographical or population) being divided between ongoing and demonstration with added demonstration workers (EPSDT case finders and case monitors) being funded through the grant. This design may be schematically depicted as follows:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(Original Version)

| | Sectors | | | |
|---|---|---|---|---|
| | A | B | C | D |
| No. of Eligibles | 4,500 | 4,500 | 5,000 | 3,500 |
| Sector Role | Exper | Exper | Exper | Control |
| | Demonstration (Project) case finders/ case monitors | | | (Ongoing) |
| | Ongoing personnel are reassigned to other areas of the city or remain in sector* but disassociate from EPSDT. *For family planning, dental program, etc. | | | Complete certain demo. forms and operation coordinated with demo. to program changes in procedures. |

As previously mentioned, the State level supervision of the project was changed from the Medical Services Specialty Division, DPW to Special Projects Bureau, DPW in July, 1975. The project was then revised and resubmitted to SRS for approval as modified. This revision placed the project under the direct supervision of Special Projects Bureau and, in a sense, established a coordinative relationship between ongoing and the project in the Dallas area. Additionally, the project was replanned to use some ongoing personnel in a demonstration role. Without the necessary leverage, however, with respect to ongoing, the required coordination between ongoing and project became increasingly nonproductive during the period covered by this report. Since, under these arrangements, it became necessary to delineate between ongoing and project case finding activities in the designated demonstration sectors, efforts were initiated to apportion the eligible population (16,581) in the area. In the first instance (February 1 - 28, 1976) one-tenth[1] of the eligibles were considered

[1]Those eligibles whose Medicaid number ended with the digit "5".

project and nine-tenths ongoing. This apportionment, of necessity, continued and the following table reflects the status of the eligible population between project and ongoing for the period of this report.

APPORTIONMENT OF PROGRAM ELIGIBLES BETWEEN ONGOING AND PROJECT
(February/June, 1976)

| Period | Last Digit of Medicaid Number | Project Population* | Ongoing Population* |
|---|---|---|---|
| Feb.1-28 | 5 | 1,658 (10%) | 14,923 (90%) |
| Mar.1-April 21 | 5 & 9 | 3,316 (20%) | 13,265 (80%) |
| Apr.22-June 30 (and current) | 3, 5, 7 & 9 | 6,632 (40%) | 9,949 (60%) |

*Predicated upon the proposal's eligible population base of 16,581.

The major context of change in the project design resulting from this activity was to convert from N (16,581 population) to n (6,632 sample). One other factor also bears significantly on this point and that is the overall decline in welfare eligibles that took place nationwide as well as in Texas, over the period from the point of project application to the end of this report period. The latest total of eligibles in the project area is now (June, 1976) approximately 14,500. In this status, the project eligibles (n) will probably stabilize at approximately 5,800. This sample is, however, still considered to be fully sufficient to validly test the hypotheses contained in the proposal.

Though the client eligibles became appropriately categorized in terms of "ongoing" and "demonstration", the fact that the project was still depending upon ongoing workers for part of their case finding efforts (in Sectors A and B) as well as the fact that the project could not maintain adequate constraints upon the ongoing control workers and their procedural activities, the project staff and the evaluators were unable to stabilize the research design and activities so as to assure the validity of the output data.

Two major administrative/managerial actions were taken by the Chief of Special Projects Bureau and the Project Director in the time frame of March - June, 1976 to bring this situation under control. First was an action to place all workers and activities in the project areas (including the two DPW Social Service Units) under the control of the Project Director. This proposal, which is graphically depicted as follows, was rejected by top levels of management in the Texas State Department of Public Welfare:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(A Revised Proposal)

Sectors

| A | B | C | D |
|---|---|---|---|
| 4,500 | 4,500 | 5,000 | 3,500 |
| EXPER | EXPER | EXPER | CONTROL |
| DPW Unit I* | | DPW Unit II* | |
| Ongoing and demonstration are all under project management control for EPSDT** | | Ongoing and demonstration are all under project management for EPSDT** | |

*Two of the six DPW Family Service Units serving the Dallas area (page 6 for additional discussion)

**Would also have probably included family planning, dental program, etc.

In this configuration the State would continue to fund the ongoing activities and the grant, the project (demonstration) activities.

In the meantime the "de facto" configuration for case finding evolved into the following schema toward the end of this report period:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(The De Facto Configuration - June, 1976)

Sectors

| | A | B | C | D |
|---|---|---|---|---|
| No. of eligibles | 4,500 | 4,500 | 5,000 | 3,500 |
| Sector role | EXPER | EXPER | EXPER | CONTROL |
| | DPW Unit I | | DPW Unit II | |
| | DPW unit splits its workers into a project support group and ongoing activities group<br>Ongoing activities work: All eligibles with Medicaid #s ending with 0,1,2,4,6 & 8 (5,400)<br>Project support group work: 3,5,7 & 9 (3,600) | | DPW unit splits its activities to allow project workers in Sector C - case finding responsibilities for 3, 5, 7 & 9. Otherwise ongoing activity has full responsibility for 1,2, 4,6,8 & C and all eligibles in D (0,1,2,3,4,5,6,7,8,9)<br>Project : 3,5,7 & 9 (2,000) | (6,500) |

This configuration may have woked if an ideal type cooperation could have been developed between the project and the ongoing activities. In the real world, however, the arrangement was fraught with frustration for both the ongoing supervisors and the Project Director. Both groups of supervisors were serving different ends and it was inevitable that this arrangement would fail to satisfy the disciplined activities needed to support valid output data for a satisfactory evaluation.

To more adequately satisfy the ends of "managed/disciplined/constrained" activities by ongoing, the Chief of Special Projects Branch and the Project Director, as the second major effort, entered into a formal agreement with the DPW Dallas Regional Director in May, 1976. This was an agreement as to specifically what ongoing and project would do in support of each other, but again, it still involved ongoing workers performing demonstration (project) defined and delineated activities. Because of the inherent conflicts built into this arrangement and its impact on the data and the evaluation, and following discussions between the Chief of Special Projects, the Regional DPW Director, the Project Director and SRS Project Officer on July 1 and 2, the decision was made to discontinue the use of ongoing personnel in the demonstration activities (except to reflect the ongoing activities--control) and to fund the case finders for Sectors A and B from the grant.

The design (schematically)as the project entered the period to be covered in the second evaluation report is as follows:

RELATIONSHIP OF ONGOING AND PROJECT PERSONNEL TO THE PROJECT
(The Final Version - July 1, 1976)

| Sectors | | | |
|---|---|---|---|
| A | B | C | D |
| 4,500 | 4,500 | 5,000 | 3,500 |
| | | | CONTROL |
| DPW Unit I | | DPW Unit II | |
| Ongoing: 1,2,4,6,8, & 0 (Non-project) | | | Components of Unit II - working Sector D - must complete project forms as stipulated |
| EXPER Project (3,5,7 & 9) (1,800 eligibles) | EXPER Project (3,5,7 & 9) (1,800 eligible) | EXPER Project (3,5,7 & 9) (2,000 eligibles) | Operations of ongoing in Sector D must be fully coordinated with the project and changes pre-planned and fully coordinated. |

This design is expected to be satisfactory in terms of meeting the objectives of the project.

# Chapter II

## CASE FINDING

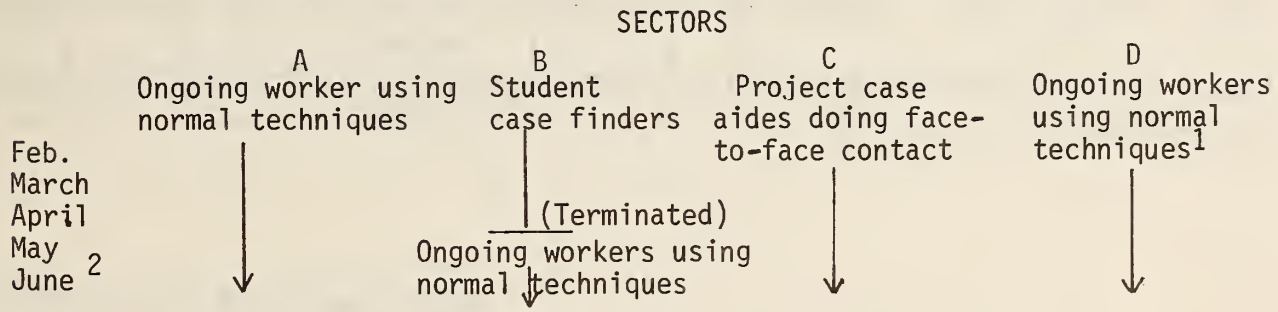
### Test Objective

As previously indicated, the major effort in case finding in this first report period was to test full time case finding aides doing exclusively face-to-face contact through home visits. A secondary effort was to test student (undergraduate social service majors requiring some field exposure for course credit) case finders using the same techniques as the case finding aides (face-to-face home contact) and being paid $3.00 per client contact showing for screen.

These two techniques were to be compared for cost and effectiveness with each other and with the ongoing (control) case finding activities. The ongoing techniques were generally the use of a letter notice to eligible clients advising them of the EPSDT program and inviting their participation in the program (estimated to be 30% of the case workers' effort); telephone communication with those clients providing an affirmative response to arrange a screening appointment (estimated as 20% of the case workers' time); and, in infrequent instances, direct face-to-face contact with the client to make a screening appointment (10% of time), or arrange transportation from the home to the screening site and return (10% of time).*

### Schema for Project Case Finding

The "de facto" schema for this case finding component of the project was as follows, for the period February 2, 1976 to June 30, 1976:




[1]30% letter contact; 20% telephone contact; 20% face-to-face contact (home visit and transportation)*

[2]A new transportation contract was let on June 1, 1976 for the Dallas Region as a whole; therefore, effective that date, routine transportation support for Title XIX EPSDT eligibles again became available.

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*The remaining 30% of case worker time effort is categorized as case monitoring (follow-up).

## Program Eligibles (Population)

The population (program eligibles) involved in both the ongoing and project components of activity in the project areas was as indicated in the table below for the respective months of the report period.

During the period of project conceptualization, as earlier stated, the total eligible population was projected at approximately 16,500 - 17,500. This population figure has varied over subsequent time however, until at present, it is in the area of approximately 14,000 - 14,500 and expected to stabilize at this general level unless other major changes in policy or economic conditions occur. In these terms, the ongoing target population in June, 1976 was approximately 8,700 and the project target population 5,600.

NUMBER AND PERCENT OF PROGRAMMED ELIGIBLES BETWEEN ONGOING AND PROJECT, BY MONTH, BY SECTOR

| | A | | | | B | | | | C | | | | D | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Ongoing | | Project (Ongoing) | | Ongoing | | Project | | Ongoing | | Proj. (Demo. case-aides) | | Ongoing | | Proj. Control (Ongoing) | | Total | | | TOTAL |
| | | | | | | | | | | | | | | | | | On-going | Pro-ject | Con-trol | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | No. | No. | No. |
| Feb. | 3706 | 91 | 352 | 9 | 3508 | 90 | 396 Student | 10 | 3529 | 88 | 465 | 12 | 3021 | 90 | 350 | 10 | 13,764 | 1,213 | 350 | 15,327 |
| Mar. | 3262 | 82 | 736 | 18 | 3059 | 80 | 761 Student | 20 | 3051 | 78 | 851 | 22 | 2570 | 79 | 691 | 21 | 11,942 | 2,348 | 691 | 14,981 |
| Apr. | 3255 | 83 | 683 | 17 | 2993 | 79 | 779 Student | 21 | 3004 | 78 | 839 | 22 | 2526 | 79 | 656 | 21 | 11,778 | 2,301 | 656 | 14,735 |
| May | 2460 | 63 | 1450 | 37 | 2311 | 61 | 1496 Ongoing | 39 | 2272 | 59 | 1558 | 41 | 1823 | 58 | 1297 | 42 | 8,866 | 4,504 | 1297 | 14,667 |
| June | 2471 | 63 | 1443 | 37 | 2215 | 61 | 1418 Ongoing | 39 | 2176 | 59 | 1493 | 41 | 1819 | 59 | 1280 | 41 | 8,681 | 4,354 | 1280 | 14,315 |

## Effectiveness Measurement Rates

The rates to be utilized in the measurement of these case finding activities are as follows:

| Rate | Formula | |
|---|---|---|
| 1. Rate of family contacts by type aide, by time (per week)<br>Original contact<br>Periodic rescreen contact | $\frac{\text{No. of family contacts by category of aide}}{\text{Weeks or months}}$ | = Rate of contact per week or month by type aide |
| 2. Rate of appointments made (of total eligible children in eligible families contacted) | $\frac{\text{No. first appointments made}}{\text{No. eligible children in families contacted}}$ | = Rate of first appmts. made at end of 90-days, by type aide |
| 3. Rate of appointments kept (of appointments made) | $\frac{\text{No. appointments kept}}{\text{No. appointments made}}$ | = Rate of appmts. kept at end of 90 days, by type aide |
| 4. Rate of shows for screening (Population penetration rate) Separate by age categories 0- 5; 6-12; 13-18; 19-20 | $\frac{\text{No. of shows for screening (of denominator)}}{\text{No. eligibles (in sectors) on last day of report period}}$ | = Rate of shows for screen (by sector) by technique being tested (by age group) |

Full-Cycle Data System

Due to the unique full-cycle aspects of the HSRI data system, for this first report some of these data will be based only on the experience for the months indicated below. The totality of the HSRI data system provides for periodic rosters to the project of incomplete actions after specified periods of time. The case finder, for example, is allowed 90 days[1] to complete (appoint) all actions pertaining to a contact. If, at the end of 90 days, data input from the project to HSRI does not indicate that all actions have been completed concerning children of a contact, a roster is sent to the project in the 14th week for all incomplete actions in the first month of the 90 day period. The project then has 21 days to attempt to complete the outstanding actions or report on reasons for inability to do so. This system has been working most effectively with this project and results in a uniquely high percentage of complete actions.

A similar follow-up system is in effect for all major case finding and case monitoring activities (to be discussed in the case monitoring chapter).

Following is a chart of actions and follow-up rosters as they pertain to the case finding subsystem. This illustrates why, in this first report, some of the data will be based on only February and March activities, since only these actions will have been through the complete full-cycle sequence.

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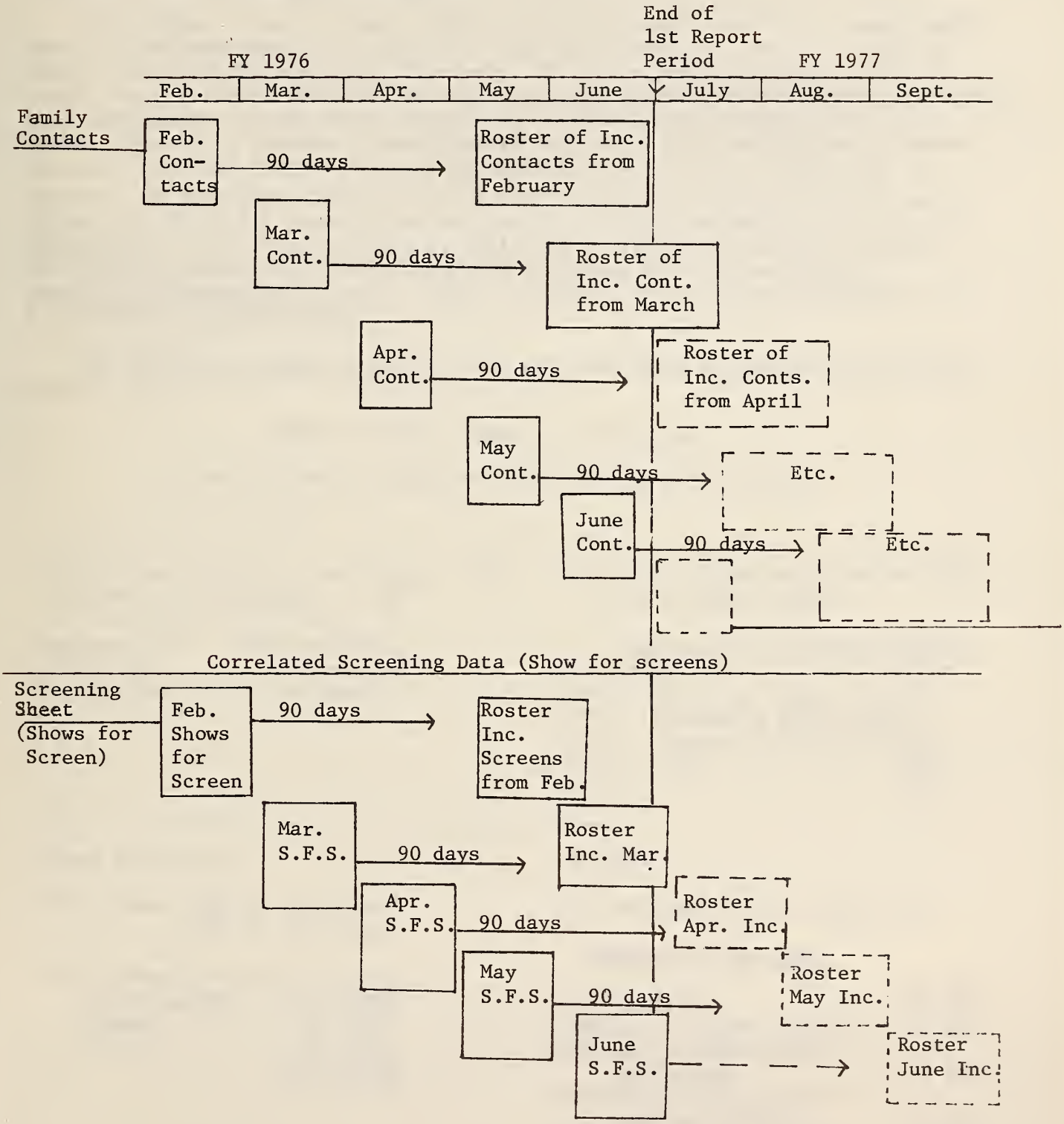
[1]Ninety days was selected as a reasonable period of time in which to expect a case finder to complete all actions on a family irrespective of the number of eligible children in the family.

THE CASE FINDING FOLLOW-UP DATA SYSTEM



Linkage - Family Contacts to Screens

The system, in one context, identifies "appointments made" and "appointments kept" (a presumed show for screen) from the family contact forms as a means to measure program effectiveness. The number of appointments not kept is the "no show" rate. A double check on the reported "appointments kept" is being developed by a name/number linkage to the "shows for screen" in the screening form data system. When this linkage is developed we will have a full-cycle data system on the most important facet of the family contact action; that is the "shows for screen". In subsequent reports, a much more intensive base of full-cycle completed actions on all forms of project activity will be presented. The significant point at this time, however, is that 100% of all family contact actions initiated in February and March have been accounted for by some form of completion/termination activity. This, in itself, if it can be maintained, is a significant accomplishment.

The following schematic depicts this activity (data derived from the Family Contact Form):

SCHEMA - FAMILY CONTACTS ACTION FLOW

244 Family Contacts (Feb/Mar) representing 649 children

183 families willing to participate (75%) in EPSDT (476 children - 72%)

Appointed for screening 469 children

Not appointed for screening - 7 children

Showed for screen

278 children (60% of appointed) (43% of contacted)

Appointments required for show

| | |
|---|---|
| First apptmt. | 211 (76%) |
| Second " | 41 (15%) |
| Third " | 26 ( 9%) |
| | 278 (100%) |

No show

191 children (40% of appointed)

Reasons for No-shows

| | |
|---|---|
| Family moved | 15 ( 8%) |
| Family no longer eligible | 39 (20%) |
| Refuses to make another appointment | 3 ( 2%) |
| Unable to contact after numerous efforts | 3 ( 2%) |
| Repeated appmt. failures | 73 (38%) |
| Other | 58 (30%) |
| | 191 |

61 families (non-participating-25%) (173 children - 28%)

Reasons for non-participation

| (Children) | | Families |
|---|---|---|
| (36) | Unable to locate | 15 |
| (21) | Refused to participate | 9 |
| (24) | Screened other programs | 9 |
| (92) | Other | 28 |
| (173) | | 61 |

The project/HSRI family contact system intends the case finder to make no less than three appointments to achieve a success (kept appointment--presumed show for screen). It is only after three unsuccessful appointments or the expiration of 90 days that the worker is permitted to drop the case as unappointable (note the 73 children "no shows" for repeated appointment failures in the schema above). It is significant to note that, had not the second and third appointment efforts been required, the show rate would have only been 45% instead of the 60% indicated and the no-show rate 55% instead of the 40% indicated. Further analysis of the no-show "other" category reveals that many of these case closures as well as some in the "repeated appointment failure" category are due to expiration of the 90 day time limit before the second or third attempt to appoint had been made. If up to three attempts to appoint had been made, the show for screen rate would have been even higher.

The ongoing activity in the same time frame (February/March) produced 1,491 appointments for screening and resulted in 739 (49.6%) shows for screen.

NUMBER AND PERCENT OF APPOINTMENTS MADE, AND RELATED SHOWS/NO SHOWS: ONGOING AND PROJECT

| | Ongoing | | Project | |
|---|---|---|---|---|
| | No. | % | No. | % |
| Appointments made | 1,458 | | 469 | |
| Shows for screen | 717 | 49.2 | 291 | 58.7 |
| No shows | 741 | 50.8 | 178 | 41.3 |

These data are too limited, for several reasons, to be considered as a valid basis for comparison. For one, as previously indicated, the ongoing's method of case finding and monitoring was in transition. Secondly, the slight variations between the project data in the table immediately above and the schema preceding it relates to the, as yet, incomplete linkages between family contact and screening systems. Thirdly, correlated cost data (see chapter on costs) for these activities were also too fragmentary, incomplete, and open to uncertain interpretation to be valid for this report period--hence are minimally included in this report only to indicate the potentialities of the overall system for subsequent reports.

## Rate of Contacts

As the schema on page 18 indicates, three categories of case finders were active in the project area during this period, i.e., (1) community service aides II (project), (2) students (undergraduate, social work program majors - project), and (3) public welfare workers (I - ongoing). The general qualifications of these three categories of case finders were as follows:

Community Service Aide II (Project Worker)

These full-time aides were generally indigenous to the project area. The job classification requires a minimum of a high school education. The salary level is approximately $6,624 - $8,352 per annum.

Students (Project Worker)

These aides were enrolled as undergraduate social work program majors in Six Dallas area colleges requiring field work internships as components of the curricula requirements. The students were generally in their junior or senior years of college (had completed at least 14 years of formal education). They were not generally indigenous to the project area. Their availability as case finding aides was highly fragmentary. They received one day's training as case finding aides prior to utilization as such. They were paid $3.00 for each child contacted that showed for screen.

Public Welfare Worker I (Ongoing and "Ongoing Designated to Support Project Eligibles" - see schema on page 16).

These case workers are not generally indigenous to the project area. The job classification requires a minimum of a college degree (16 years). The salary range is approximately $9,840 - $12,408 per annum. They work full time but, as earlier indicated, generally split their time to case finding at approximately 70% and to case monitoring (follow-up) at 30%.

The case aides (Community Service Aide II) and the students were intended to use identical home visit methods of client contact and work under the same constraints, such as non-availability of public provided transportation for clients to screening sites, etc. Both categories of project case finding aides were responsible for introducing clients to those other services of the Texas State Department of Public Welfare, such as (1) the EPSDT program, (2) the State Title XIX dental program (Dental EPSDT corollary), and (3) family planning services. Both were assigned cases for contact by their respective supervisors. Further details of supervision, overlapping supervision of students, availability of time for students, etc., are discussed in detail in the attached special in-depth study of the student case finders (enclosure 1 ).

As previously indicated, there was a lack of project control over the techniques employed by the Public Welfare Workers (ongoing designated to support project eligibles) and they must be considered as having continued to use the primary ongoing techniques of letters, phone calls to affirmative responses to the letters, and, in infrequent instances, direct home contact.

During this report period the number of family contacts by type of case finding worker (full-time equivalent) and time was as follows:

FAMILY CONTACTS BY TYPE CASE FINDER (FTE)* BY MONTH
(February - June, 1976)

| | Full time Case-finding Aide | | | Student Case-finding Aide | | |
|---|---|---|---|---|---|---|
| | # Contacts | FTEs | Contacts per FTE | # Contacts | FTEs | Contacts per FTE |
| Feb. | 97 | 3 | 32.3 | 15 | .35 | 42.9 |
| March | 79 | 2.4 | 32.9 | 52 | .54 | 96.3 |
| April | 32 | 2.3 | 10.7 | 70 | .52 | 134.6 |
| May | 89 | 3 | 29.7 | Activity discontinued - | | |
| June | 89 | 3 | 29.7 | (See narrative) | | |
| Total | 386 | 13.7 | — | 137 | 1.41 | — |
| Average | 77.2 | 2.74 | 28.2 | 45.7 | .47 | 97.2 |

These data produce the following work load analysis, leading ultimately toward the development of work load planning factors for case finding personnel.

| | Full time Project Case-finding Aides | Student Case-finding Aides |
|---|---|---|
| Average family contacts per month | 77 | 46 |
| Average family contacts per week(4.35 wks per mo.) | 17.7 | 10.57 |
| Average family contacts per day (5 days per week) | 3.54 | 2.11 |
| Average family contacts per week per FTE | 6.46 (2.74 FTEs) | 22.49 (.47 FTEs) |
| Average family contacts per day per FTE | 1.29 | 4.49 |

*Full Time Equivalents

On first glance, the data would appear to suggest, on the basis of contacts alone, that the student case finders are more effective than the full-time case finding aides. However, the students were allowed to conduct their case finding effort in a non-rigorous manner; many of them did not follow through on three attempts to successfully appoint a family, but rather, closed a case after only one attempt. This one-shot approach allowed the students time to make more contacts per unit of time, thereby inflating their full time equivalent contact rate per day. (See section on student case finding for further explanation.)

Original planning for this research to determine appropriate task performance

measurement (yard sticks) for full time, face-to-face aides included projections of one family contact per hour per eight hour day, or 40 per week. Even acknowledging that this projection was quite theoretical, the current rate of 1.29 per day per FTE would, on the surface, appear to price this option out of consideration. In order to insure that this contact rate was not misrepresentative due to one casefinder being out of line with the others, the individual rates were compared and found to be essentially the same when averaged over the five month period. Nevertheless, there are indications that case finders often cannot give a client a screening appointment earlier than four weeks in advance. This has an impact on possibly inhibiting case finding activity in that some workers are reluctant to appoint clients so far in advance. The whole matter of appointment availability, kept appointment rates, etc., bears on this problem and requires careful consideration.

As already repeatedly indicated, these data are too fragmentary to be conclusive and perhaps, with greater worker job experience, closer supervision, and reduced lags in appointment availability timing, this rate will materially improve in the future. This activity will require discussion between the project and the HSRI for further consideration.

Rate of Appointments Made

As previously indicated, "appointments made" is a factor of a time span in a total sequence of management activities (incomplete visits, etc.) covering three months, whereas contacts, per se, (discussed above) occur in a pinpoint of time. Therefore, the following data on appointments made by three categories of case finders are discussed only for February - March as completely sequenced actions.

FAMILY CONTACTS, CHILDREN REPRESENTED & APPOINTMENTS MADE, BY THREE CATEGORIES OF CASE FINDERS (Feb/Mar 76)

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|---|
| | Number Family Contacts | No.Children Represented by Families Contacted | No.Families Willing to Participate in EPSDT | Children Represented by Families in Column 3 | No.Apmts. Made for Children Who will Particip. | Rate of Apmts. Made of those Willing | Rate of Apmts. Made of those Contacted |
| | | | Case Finding Aides | | | | |
| Feb. | 97 | 270 | 78 | 203 | 203 | 100% | 75% |
| March | 79 | 199 | 64 | 161 | 153 | 95% | 77% |
| | | | Student Case Finders | | | | |
| Feb. | 15 | 31 | 13 | 27 | 26 | 96.3% | 84% |
| March | 52 | 149 | 28 | 85 | 85 | 100% | 57% |
| | | | Ongoing Case Workers | | | | |
| Feb. | /// | /// | /// | /// | 596 | --[1] | |
| March | /// | /// | /// | /// | 895 | -- | |

[1]These data are not yet available but are presumed to be in the same range as for aides and students (95-100%). See earlier discussion on organization relationship with "ongoing" activities.

As the above data indicates, once a mother (sponsor) has indicated a willingness to participate in the program, she will almost always agree to having a screening appointment made (95% - 100%). In some degree, the agreement to participate and be appointed for screening is intended by some mothers to be a "real" positive action but, to some other degree, is representative of a "pacifying" response to the case finder. In other words, "yes" at the point of contact gets the case finder "off the client's back" at that time. When the procedure reaches the point of keeping the appointment (show for screen) however, where the mother must take an action to keep the appointment by dressing herself and the children, going out of the house, getting transportation, going to a screening site, etc., to a great extent the degree of "real" intent to participate in the program manifests itself. It is at this point that the system experiences its greatest loss of effectiveness, with "appointments kept" rates ranging from only 30% to 60% (see following data on rates of appointments kept) of appointments made. This critical point in the system will continue to be a major focus of this project's demonstration effort.

Rate of Appointments Kept

This rate also is a factor of time and a sequence of activities and, therefore, is reported for February and March only.

NUMBER AND RATE OF SCREENING APPOINTMENTS MADE AND KEPT AS RELATED TO THREE CATEGORIES OF CASE FINDERS (Feb/Mar 76)

| | No. Appointments Made<br>1 | No. Appointments Kept<br>2 | Rate of Appointments Kept<br>(2 ÷ 1 = 3) |
|---|---|---|---|
| | | Case Finding Aides | |
| Feb. | 203 | 132 | 65% |
| March | 153 | 91 | 59.5% |
| | | Student Case Finders | |
| Feb. | 26 | 23 | 88.5% |
| March | 85 | 36 | 42.4% |
| | | Ongoing Case Workers | |
| Feb. | 596 | 279 | 46.8% |
| March | 895 | 460 | 51.4% |

Again, repeating the caution concerning the preliminary character of these data, it is significant to note that the second month's rate of appointments kept for both the case finding aides and the student case finders moves in the

direction of the ongoing rate. As indicated in the discussion on the preceding page, this rate is one of the critical points in the system and will be a major focus of project activity. There are many other facets of this problem, such as time lags between dates of contacts and screening dates, availability and character of transportation, reminders to clients just prior to the screening appointment, etc., that will be in a better context for evaluation in the next report.

Rate of Shows for Screening

This is the critical rate for analysis of the case finding subsystem. The shows for screening as a component of the total eligibles in the various sectors and project is the penetration rate--the rate of the eligible population's involvement in the EPSDT program. There is a secondary, less critical show rate and that is of children appointed for screening, which was discussed on the previous page. This latter rate may be more a factor of case finding technique analysis, whereas the primary rate is more a factor of population program cognizance and responsiveness. This is a time/point analysis covering the program eligibles as of June 30 and reflecting those eligibles at that point that had showed for screening in the preceding five months (February - June) and projecting these data to an annualized rate.

PROJECTED (ANNUALIZED) ELIGIBLE POPULATION PENETRATION RATE (ELIGIBLES vs SHOWS FOR SCREEN) BY SECTOR AND BY AGE GROUP

| All Ages | 1<br># Eligibles on June 30'76 (3, 5, 7, & 9s) | 2<br># Eligibles (Col. 1) who "showed for screen" Feb-June (5/12) | 3<br># Projected to Show at Feb/June rate annualized (12/12) | 4<br>Projected Penetration Rate (1 ÷ 3 = 4) |
|---|---|---|---|---|
| (By Sector) | | | | |
| Sector A | 1,443 | 229 | 550 | 38% |
| B | 1,418 | 143 | 343 | 24% |
| C | 1,493 | 344 | 826 | 55% |
| D | 1,280 | 205 | 492 | 38% |
| Total | 5,634 | 921 | 2,210 | 39% |
| (By Age) | | | | |
| Age 0 - 5 | 1,896 | 316 | 758 | 40% |
| Age 6-12 | 2,062 | 373 | 895 | 43% |
| Age 13-18 | 1,383 | 204 | 490 | 35% |
| Age 19-20 | 293 | 28 | 67 | 23% |
| Total | 5,634 | 921 | 2,210 | 39% |

One difficulty arises with these data in this report period in that a number of the eligibles on June 30, 1976 were not project cases throughout the whole period because of the phased apportionment of the eligibles between ongoing and the project, previously discussed. The above data and resulting rates incorporate some aspect of mixture (in February and March) between ongoing and the project, sufficient to cause minor distortions in these data, which will be diminished or eliminated in subsequent reports.

Nevertheless, these data reveal some fascinating possibilities. The schema on page iii (attachment to the Summary) reveals that 649 children (244 families) were contacted in February and March, 1976 to obtain 278 shows for screen. This represents 2.33 child contacts per show for screen. If this factor is applied to the projected (annualized) shows for screen (826) for Sector C from the above table, it indicates that 1,924 (826 x 2.33) children or 129% of the eligibles would need to be contacted by the end of January, 1977. In other terms, it appears as if all the eligibles in Sector C will have been contacted at least once by approximately mid-November, 1976. This would be reasonably absolute if all the contacts were for original screens; however, a certain percent of these contacts were for periodic rescreens. It is of interest to note that, of the family contacts conducted in February - March, 1976, 63% were new (no prior contact) and 37% were periodic rescreens. This percentage distribution is reinforced by the fact that, of the screening done in February and March on individual children, 68% were originals and 32% were periodic rescreens. This distribution appears to represent an inordinate effort on rescreens, since in a real sense these families are already in the EPSDT system (though not necessarily all the children) and there is still an abundance of new contacts to be made. It is generally accepted that a family not heretofore in the system offers greater potentiality for program achievement and, therefore, should represent the predominant effort. Since this matter was surfaced early in the project activity, it is assumed that by the next report a higher concentration on original screens will be reflected in the case finding system.

Notwithstanding, the potential saturation of the eligibles in Sector C and in other sectors later in the next year requires a programmed change in direction (new variables for testing). It appears that the major challenge should be to find means to materially increase the show rate for contacts made. If this cannot be accomplished by variations in the face-to-face, in-the-home technique, the estimated less costly ongoing technique of letter/phone follow-up may, in the end, be the most effective and cost beneficial method of case finding. In these terms, it could possibly mean accepting that penetration (shows for screening of eligibles) in the EPSDT program might never exceed 50%. This area of definition is still one of the two major challenges in the EPSDT program and will remain the main thrust of the project effort for the balance of this fiscal year.

Student Case Finders

As earlier indicated, this case finding variable was approved for testing as a substitute during the first year. The project, however, terminated this variable after three months of testing because of difficulties with a

multi-level supervisory responsibility for administering the students and their activities. The three month time exposure for this variable is considered inadequate for reliable conclusions, particularly in view of the fact that transportation was not available for EPSDT clients in the Dallas region at that time. A detailed special study was done on the activities, effectiveness and relative costs of the student case finders by the HSRI On-site Coordinator (Ms. Nancy Barbas). A copy of this study is enclosed. It also concludes that the variable has good potentialities, could possibly be administered in other modes, and is worthy of further study. This matter was discussed at a conference between the SRS Project Officer, the Project Director, and the evaluators, and the conclusion reached as follows:

As an approved SRS variable, findings related to it should be conclusive one way or the other, if possible, and since the three month test does not satisfy this condition, the variable should be reconsidered for testing in other configurations in FY 78.

Full Time Case Finding Aides (Face-to-face contact)

Conclusions relating to the effectiveness and cost effectiveness of this variable will be included in the next evaluation report when six additional months of data will be available for analysis.

At this point, the population contact rate appears to be good, but the "pay off" on related shows for screens is yet to be substantiated (See earlier discussion "Rate of Shows for Screening", pages 28 and 29).

# Chapter III

# CASE MONITORING

## Test Objective

As earlier established, the major effort in case monitoring in this first year was to test full time case monitors of various skill levels to ascertain at what minimum skill the maximum number of screen completions, immunization completions, problem completions, and case completions could best be achieved.

## Test Comparisons

Three skill levels were to be tested, using generally the same follow-up techniques. The skill levels were (1) Public Health Nurse, (2) Social Worker, and (3) Case Monitor Aide. The general qualifications of these three categories of case monitors were as follows:

### Public Health Nurse

A Registered Nurse with one and a half years hospital nuring experience was hired for this position. She had some public health experience as a student intern. Her case monitoring training was provided by a three day Dept. of Public Welfare orientation session, instructions informally presented by the direct services supervisor, and followed by field training with the Social Worker Case Monitor. The salary range for the Public Health Nurse is $12,000 to $15,108.

### Social Worker

Qualifications for the position of Social Work Monitor included minimum education of a Bachelor's Degree, with a Master's Degree in Social Work or two years social service work experience. The position (Public Welfare Worker III) was filled by an individual with three and a half years social work experience in the Dept. of Public Welfare, six months of which included responsibility for follow-up activities. No formal training for the Social Work Case Monitor was received by this individual during employment by the Demonstration Project. The salary range for this position is $11,232 to $14,148.

### Case Monitor Aide

This position was filled by a Community Service Aide III, with a high school education, one year of college, some community experience, and who lived in the geographic project area. The Aide attended the formal two week training course specific to EPSDT and the research project. The course was designed for individuals who lacked social service and EPSDT experience. (Further detail on the course can be found in the manual "Training Program for Case Finders and Case Monitors in EPSDT" prepared by HSRI). The salary range for this position is $7,580 to $9,528.

These three skill levels will be compared with each other as well as with the "completion" rates for clients and problems in the ongoing program (control). This latter comparison will be done by a special sample study since ongoing makes no follow-up effort beyond show for treatment and does not designate specific personnel as case monitors. Case monitoring is generally done by ongoing case workers who have case finding, as well as case monitoring and other responsibilities. In the past (prior to the project), little time was found available by ongoing case workers for case monitoring. Concurrently with the initiation of the project, however, the State required that new Problem Referral (402) and Problem Referral Supplement (402S) forms be used by both project and ongoing EPSDT activities in the Dallas area as a test for these forms pending consideration for statewide adoption. The use of these forms, according to ongoing supervisors, did stimulate increased case monitoring in the ongoing program (estimated from 10% to 30%), but since the forms were utilized from the outset of the project, it is postulated that the base of activity (control) stablized in this report period. It, however, doubtlessly represents a higher base of case monitoring activity than the State at large (which does not use the new 402/402S). The report for the next period will contain some data on completion rates achieved by ongoing workers prior to the project. This data is not being reported here because there is nothing to compare it with, due to the time sequencing of the 402 system. The project follows the individual problem (case, etc.) beyond show for treatment to completion or resolution by using a data sheet supplemental to the 402/402S.

## Sources of Data

Whereas, in original concept it was hoped that the project data on completions and resolutions would come primarily from the practitioner treating the children, the State (DPW/DHR) ruled that no contacts could be made by project workers with physicians beyond any contact inherent to the new 402/402S system (to show for treatment). This required the project to primarily base its data on completions and resolutions, such as the status of the problem (treatment completed, still under treatment, referred to other practitioner, etc.) on information obtained from mothers and children--a less reliable source of data. This decision by the State was predicated upon a high level of sensitivity to the medical profession's possible unfavorable reaction to additional administrative requirements being associated with EPSDT in a time frame in which the State was preparing to introduce its new EPSDT forms (402/402S) statewide.

## Schema for Project Case Monitoring

The schema for the case monitoring component of the project was as follows for the period February 2, 1976 to June 30, 1976:

SCHEMA - EXPERIMENTAL CONFIGURATION FOR CASE MONITORING

Sectors

| | A (Experimental) Public Welfare Worker III* | B (Experimental) Community Service Aide* | C (Experimental) Public Health Nurse* | D (Control) (Ongoing)** |
|---|---|---|---|---|
| Feb. | ↓ | ↓ | ↓ | ↓ |
| Mar. | | | | |
| Apr. | | | | |
| May | | | | |
| June | | | | |

* Full time case monitoring of problems, etc., identified with clients from the respective sectors.

**The ongoing methodology for case monitoring is as one of several functions for a case worker who has case finding responsibilities and others as well as case monitoring. (estimated to be at approximately 30% of time at the end of this report period).

Rates for Measuring Case Monitoring Activities

The rates to be utilized in the measurement of the case monitoring activities are as follows:

| Rate | Formula | |
|---|---|---|
| 1. Rate of Problem Completions (Single problem) | # Confirmed problems resolved (completed) / # Confirmed problems (by sector/type case monitor) | = Rate of problem completions by sector/type case monitor |
| 2. Rate of Case Completions (Multiple problems) | # Case completions or resolutions (of cases in denominator)[1] / # Confirmed unwells (2 problems) (3 problems)(4 problems)(5 or more problems) (sector/type monitor) | = Rate of case completions (sector/month) |
| 3. Rate of Screen Completions (of shows for screen) AND Periodic Rescreen Completions | # Screens completed (of shows in denominator) / # Shows for screen (sector/type aide) | = Rate of screen completions (sector/month) |

[1]Generally at the end of 180 days (180 days following problem sheet initiation).

| | | | |
|---|---|---|---|
| 4. Rate of Immunizations (current for age) | # Immunizations current for age at end of 150 days (for denom.) / # Immun. not current for age at point of entry to initial visit (shows for screen) | = | Rate of immunizations completed (sector/month) |

The 150 day cycle was chosen for the immunizations on the basis of 120 days as the appropriate sequencing of a series of three immunizations with ideal appointment keeping--and allowing another 30 days for missed appointments.

The 180 day cycle for problem sheets was based upon experience with other projects in which approximately 95% + of problems are appropriately resolved within 180 days, with only the few long term cases remaining for continued treatment or observation.

The data information flow is established so that a first copy of each sheet (screen/immunization/problem) opens up the system to each child and a second copy representing completion or resolution must be received to close the system. The incomplete rosters simply represent those first copies of forms which have not been matched by second copies for a given month after the indicated action periods (90 days/150 days/180 days).

As should be apparent from the foregoing, only two monthly cycles (February/March) of the screening sheet were completed during this report period and none of the immunization and problem sheets.

The data on the two completed cycles for the screening sheet were contained in the chapter on case finding (page 23).

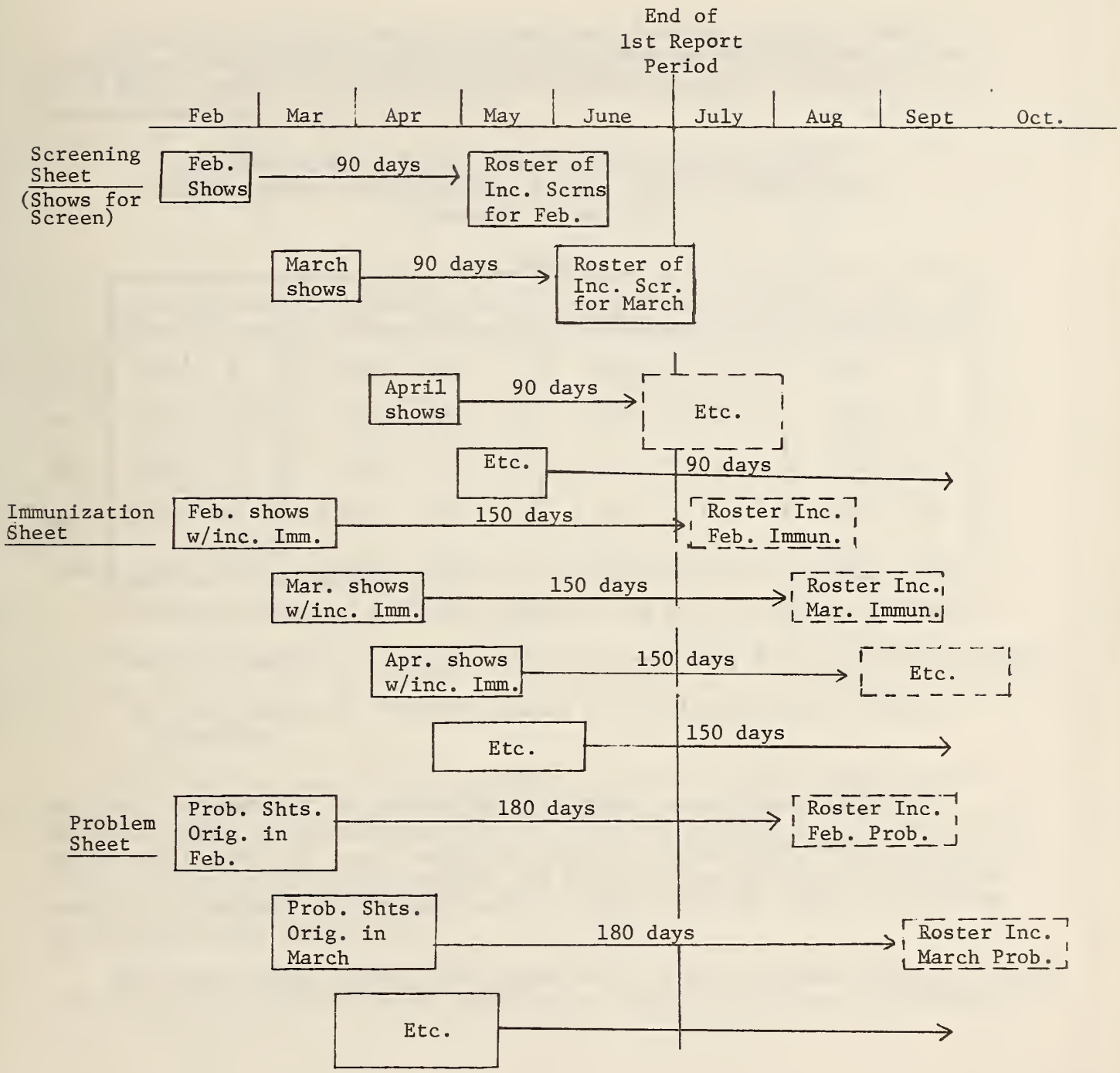
Organizational Problems

The other facets of activity in the project during this period that hampered the effectiveness of the case monitoring data were the early problems between ongoing and the project in organization delineation discussed in the introductory chapter (pages 13 to 17). As discussed there, the changing structure of the demonstration population limited the number of cases available for follow-up.

Full-cycle Data System

The HSRI case monitoring data system is, as the case finding data system, a full-cycle system. All screens initiated, problems found, immunizations incomplete, must be accounted for and appropriately resolved or terminated. Follow-up rosters are sent by the HSRI to the project on incompleted actions in accordance with the following time schedule:

THE CASE MONITORING FOLLOW-UP DATA SYSTEM



The 90 day cycle was chosen for the screen to allow adequate time for laboratory results to be returned from State laboratories (sometimes as long as 30 days), recall of clients for retesting when necessary, resubmission to laboratories, etc.

CASE MONITORING: ELIGIBLE PROJECT POPULATION BY SECTOR, PROJECT NUMBER AND PERCENTAGE OF TOTAL ELIGIBLE POPULATION (February - June 1976)

| | Sector | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | A | | B | | C | | D | |
| | No. | % | No. | % | No. | % | No. | % |
| Feb.[1] | 352 | 9 | 396 | 10 | 465 | 12 | 350 | 10 |
| Mar.[2] | 736 | 18 | 761 | 20 | 851 | 22 | 691 | 21 |
| April | 683 | 17 | 779 | 21 | 839 | 22 | 656 | 21 |
| May[3] | 1,450 | 37 | 1,496 | 39 | 1,558 | 41 | 1,297 | 42 |
| June | 1,443 | 37 | 1,418 | 39 | 1,493 | 41 | 1,280 | 41 |

[1]Medicaid numbers of eligibles ending in the digit 5 (10% of eligibles)

[2]Medicaid numbers of eligibles ending in the digits 5 & 9 (20% of eligibles)

[3]Medicaid numbers of eligibles ending in the digits 3,5,7& 9 (40% of eligibles)

Since only the case finders in Sector C were fully under project control for the five months of the period and the student case finders in Sector the three months of February/March/April, there was no means for the project to assure equal levels of case finding activity for digits three, five, seven and nine in Sectors A and B (two months), and Sector D, thereby also affecting the monitoring caseload. (As reported earlier, this problem has been rectified for the following year's activities.)

The project cases showing for screen in the first five months were as follows, with the correlated problems and immunizations requiring follow-up identified:

SHOWS FOR SCREEN AND RELATED PROBLEMS, AND IMMUNIZATIONS REQUIRING FOLLOW-UP
(February - June 1976)

| | Sections | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | A | | | B | | | C | | | D | | | Total | | |
| | Shows for Screen | Related Problems | Incomplete Immunizations[1] | Shows for Screen | Related Problems | Incomplete Immunizations | Shows for Screen | Related Problems | Incomplete Immunizations | Shows for Screen | Related Problems | Incomplete Immunizations | Shows for Screen | Related Problems | Incomplete Immunizations |
| Feb. | 8 | 3 | | 20 | 1 | | 53 | 15 | | 12 | 4 | | 93 | 23 | |
| Mar. | 18 | 2 | | 48 | 3 | | 108 | 14 | | 24 | 6 | | 198 | 25 | |
| Apr. | 61 | 8 | | 23 | 3 | | 36 | 7 | | 16 | 5 | | 136 | 23 | |
| May | 64 | 8 | 11 | 8 | 0 | 2 | 90 | 22 | 5 | 57 | 11 | 1 | 219 | 41 | 19 |
| June | 30 | 7 | 16 | 12 | 1 | 6 | 74 | 8 | 10 | 76 | 13 | 18 | 192 | 29 | 50 |
| Total | 181 | 28 | 27 | 111 | 8 | 8 | 361 | 66 | 15 | 185 | 39 | 19 | 838 | 141[2] | 69 |

[1]Relates to children ages 0 - 6 only, whereas other categories apply to all ages (0 - 21). Predicated upon Health Department guidance that assumes all children who are admitted to school are current for age in compliance with State laws.

[2]141 problems in 120 children; 21 children had two problems each.

One hundred and twenty children, as indicated by the screening system, were identified for referral out of 838 screens (14.3%). This is somewhat lower than would be anticipated. In making comparisons with other programs, it is again necessary to indicate that the Texas EPSDT program and the Dental Title XIX programs for children are separate. The referrable conditions are medical only. In these same terms (medical only), using the total of all screens and referrable problems reported by all states (including Texas), 18% of children screened have referrable conditions.[1] This figure is considered low since it reports all programs of all degrees of effectiveness. In this same report, Michigan, which is screening at about the same level as Texas, reports 27% of children screened with referrable conditions. The range of 25 - 30% of referrable medical conditions found from screening is consistent with other data. The Health Start Program, at the conclusion of a two year study (evaluation), reported 26.8% of the Medicaid eligible children in the program with referrable medical conditions.[2] The State of Texas as a whole reported 28% of children screened with referrable medical conditions.[1]

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[1]DHEW Publication No. SRS 76-03150, NCSS Report B-1 (2-76), June, 1976.

[2]Health Start: Final Report of the Evaluation of the Second Year Program, Leona M. Vought, et al, The Urban Insitute, Washington, D.C., December, 1973.

As repeatedly indicated in the report, these are preliminary data requiring further study and refinement. One of several (or a combination of) causative factors must be considered as possibilities for explanation of the "problem referral rate", e.g., (1) the children of Dallas are generally healthier, (2) standards for referring vary; or (3) there are errors in data collection. These data require further investigation. The problem rates for original vs periodic screens were compared to determine if the level of periodics being screened might be a contributing factor to the low referral rate. For the months of February through June, the referral rate for original screens was 16% and for rescreens, 12%. Although there is a slight difference in the rates, it is not enough to explain the overall differences discussed above.

Rates

Rate of Problem Completion
Rate of Case Completion
Rate of Immunization Completions

The above rates will be incorporated into the next evaluation report which will then include completed follow-up cycle data as applied to these rates.

Rate of Screen Completions

The screens initiated in February and March have now completed the full 90-day follow-up cycle.

In terms of completed sequences, 100% of Sheet No. 2 (the follow-up sheet) have been matched with the screening initiation sheets. This, in itself, is a major system accomplishment. The analysis of these actions is as follows:

291 Screens Initiated

Screens Completed

38 (13%)
or
291 (100%)

Screens Incomplete

253 (87%)
or
0 (0%)

| Reasons for incompletions | No. |
|---|---|
| Laboratory or other tests not administered or results not available | 253 |
| Family moved | 0 |
| Family no longer eligible | 0 |
| Refuses to make another appointment | 0 |
| Unable to contact after numerous efforts | 0 |
| Repeated appmt. failures | 0 |
| Other | 0 |

The screen, to be complete, needs to include not only the child's family history, physical examination, developmental assessment, vision and hearing testing, temperature and blood pressure readings, height and weight measurements, immunization status, but also the following additional tests:

1. Urine tests, to include:

   a. Urine sugar (diabetes test)
   b. Urine albumen
   c. Urine bilirubin
   d. Urine blood

2. Blood tests

   a. Hemoglobin (anemia test)
   b. Hemoglobinopathies (sickle cell tests (blacks only))
   c. RPR (VD test)
   d. Lead test (children under age 5)
   e. PKU test (children under age 1)

3. TB (Mantoux) (for children over six months of age)

The foregoing schema indicates a basic screen completion rate of 13%. As is evident from these data, if the element of "laboratory or other tests not administered or results not available" were excluded, the completion rate would be 100%. This latter rate is the rate the Health Department would consider correct. The problem in this situation for the evaluator is that, for example, the standard provided by the Dallas Health Department prescribes a "TB Mantoux" for all children over six months of age, without other qualifications. Nevertheless, there are many instances in which children over six months are not administered the TB Mantoux. From a data entry point of view, we have no alternative but to categorize these as incomplete. The RPR test is another example where the guidelines prescribe its administration without qualification, but in a number of instances, the blood sample is hemolyzed when it reaches the State laboratories--the test cannot be performed and no result is available for recording. Again, from the data entry and analysis point of view, without a basis for programming exceptions, we have no alternative but to consider these as incomplete screens based upon omission of a test result. It is because of this dichotomy that, in this evaluation, we are reporting both rates of completion.

In a similar vein, the Dallas Health Department's retest policy on "positive" test results is in the context of a "one shot" screen. The original HSRI data system was designed to reflect an incomplete sequence for all positive results not retested.[1] It has been reprogrammed in this situation to reflect an incomplete on a retest only when a retest is specifically (rather than routinely) prescribed. This "one shot"[2] approach is favorable for higher screen

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[1] A Guide to Screening. American Academy of Pediatrics, June, 1974.

[2] "One shot": a screen completed in one visit.

completion rates--and conceptually, is a desired objective. It usually, however, presupposes that laboratory tests are administered and evaluated (read/interpreted) at the time of screening, or a means provided the mother to read the results.* In the Dallas situation, most laboratory tests are sent to the State laboratory for analysis with results available to the screeners in the deferred sequence of 14 - 21 days.

Problems Identified in Screening

The flow chart (page iii) also indicates that, of the screens in February and March, 254 or 87% reflected no problems (a "well" child), and 37 or 13% with problems (an "unwell" child).

Of the 37 unwell children, 48 problems were identified (11 children had two problems each). A breakdown by condition category based on available data (35 of the 48 problems) follows:

| No. | | Category |
|---|---|---|
| 0 | | I Nutritional |
| 3 | | II Blood disease |
| 0 | | III Mental |
| 5 | | IV Eyes (disease or injury) |
| 7 | | V Vision (sight) |
| 2 | | VI Ears (disease or injury) |
| 0 | | VII Hearing (deafness) |
| 2 | | VIII Respiratory |
| 0 | | IX Dental |
| 2 | | X Skin |
| 14 | | XI Other |
| | (2) | - - Orthopedic |
| | (3) | - - Genito-urinary |
| | (1) | - - Pregnancy |
| | (2) | - - Heart murmur |
| | (3) | - - Blood lead |
| | (1) | - - Throat nodule |
| | (1) | - - Low height and weight |
| | (1) | - - (History) rheumatic fever |
| | (14) | |

These data as related to normal "expectancy" rates of conditions found can only be evaluated when a sufficient data base is established (next report) and when the problem of the low referral rate previously discussed is resolved.

*Such as the Lederle-Tuberculin Tine Test Record (self-reader), utilized in the Pennsylvania EPSDT program.

# Chapter IV

## COSTS

In the chapters on case finding and case monitoring, rates were identified which would be used to evaluate the effectiveness of the variables being tested in the respective subsystems. The full impact of these rates, however, also has to be considered in terms of their costs. The complete expression of the rates including costs, is as follows:

### Case finding

| Effectiveness element | Cost element |
|---|---|
| (1) Rate of "shows for screen" to eligible population, by technique being tested, by sector | *per average cost per show |
| (2) Rate of "family contacts" per week, by type aide | *per average cost of contact |
| (3) Rate of screening appointments made to children in family contacted (sector) | *per average cost of screening appointment |
| (4) Rate of appointments kept (shows for screen) to children appointed, by technique (sector) | *per average cost of appointment kept |

*Case finding subsystem costs divided by the average number of actions in a specific time frame.

### Case monitoring

| Effectiveness element | Cost element |
|---|---|
| (1) Rate of problem completions, of problem sheets initiated (by time) by type monitor (sector) | *per average case monitoring cost of problem completions |
| (2) Rate of case completions (of multiple problem sheet cases initiated, by time) by type monitor (sector) | *per average case monitoring cost of case completions |
| (3) Rate of screen completions of screening sheets initiated, by time, by type monitor (sector) | *per average case monitoring cost of screen completions |

| | |
|---|---|
| (4) Rate of immunization completions of immunization sheets not completed at screening, by time, by type monitor (sector) | *per average case monitoring cost of immunization completions |

*Case monitoring subsystem costs divided by the average number of actions in a specific time frame.

All the guidelines, forms (examples attached), instructions, etc., for collecting and reporting cost data by the project are included in the EPSDT Demonstration Model - Evaluation Handbook published by HSRI in May, 1975.

The system devised was, to a great extent, a result of the Institute's experience in establishing cost data systems for the "old" demonstration projects (i.e., Cuba, New Mexico; Contra Costa, California; Washington, D.C.; San Antonio, Texas).

The cost elements of analysis, e.g., average cost of shows for screen, average cost of problems completed, etc., are dependent upon

(1) accurate reporting of project employee hours by subsystem or designated major activity;

(2) accurate reporting of total costs per month chargeable to <u>specifically designated accounts.</u>

<u>Direct costs</u>, such as salaries, screens, treatments, etc., are relatively easily identified with subsystems (case finding, screening, diagnosis, treatment and case monitoring) for specific components of time (or sector).

<u>Indirect costs</u> such as rent, utilities, maintenance, depreciation and administrative support (e.g., recruiting, classification, etc.) are generally not as easily identified with a subsystem. To overcome some of these difficulties, the HSRI cost system prescribes the charging of indirect costs to subsystems or major activities, based upon the percent of personnel hours committed to each subsystem. Nevertheless, it was anticipated, particularly in governmental activities in which indirect costs such as utilities and rent are often programmed by an organizational activity other than the EPSDT operation, that the total indirect costs by category chargeable to the EPSDT activity per element of time would be difficult to obtain.

This was the case in the Dallas project and the major factor in diluting the reliability of the cost data for the first three months of the project's activity (February, March, April). The project is a unit of the State Department of Public Welfare and shares a building and associated services with several other functional activities, a situation which, under the prevailing accounting method, apparently does not readily relate costs to activities. The Project person

designated to complete the cost data (Mr. Don Akerblom - Administrative Assistant) was unable to acquire the delineated costs (charges) from the appropriate officials in the Dallas area for the time frame of this first report. alternate solution, the project used a State provided figure (used in State planning for indirect costs) for computing the indirect project costs. This figure, $892 per person per year,[1] is being used in this report pending the development of the actual costs in the project area for subsequent reports.

A second factor adversely affecting the collection of cost data was the organizational problem between "ongoing" and the project that was discussed in depth in Chapter II, Case Finding. Since Phase I (establishing a data base representative of the ongoing activity) was omitted, the cost data from the control sector is vital for comparison purposes. Difficulty in obtaining time sheets from "ongoing" workers without leverage to assure delivery created a void in cost data from ongoing for the period of this evaluation. This matter was presumably brought under control at the beginning of the second report period when the organizational dichotomy between ongoing and the project was resolved.

Because of the limited time frame represented by this report, the greater limitation on completed (full cycle) data, and the difficulties in initiating "start up" data, only the most minimal cost data will be included in this report, and again, it is cautioned that these would be preliminary indicators and basically unreliable for program usage.

Overall Costs

(1) Direct Services Costs (excludes project overhead/management, etc.)

| Period | FTE's[1] | Hours Worked | Direct Costs Personnel | Direct Costs Travel | Indirect Costs[2] | Total Costs |
|---|---|---|---|---|---|---|
| Feb-Mar | 8.31 | 2,730 | $14,655 | $683 | $1,283 | $16,621 |
| Apr-May-June | 9.50 | 4,447 | 24,161 | 717 | 2,119 | 26,997 |
| | | | | | | $43,618 |

[1]Project case monitors, case finders, and inherent supervision and support.

[2]Using State planning figures (see narrative).

[1]Includes all indirect operating expenses (rent, utilities, telephone, equipment maintenance, furniture, special equipment, postage, gasoline, oil). It does not include consumable supplies (paper, forms, pencils, etc.). (It is an HSRI estimate that the inclusion of consumable supplies would alter the figure by, at most, 1 - 2%).

(2) Total Costs ($43,618) by Functional Category

| Period | Case Finding | Case Monitoring | Orientation & Training | Administration & Management | Total Costs |
|---|---|---|---|---|---|
| Feb-Mar | $ 6,670 | $ 6,998 | $ 691 | $2,262 | $16,621 |
| Apr-May-June | 10,164 | 12,540 | 1,634 | 2,659 | 26,997 |
| | $16,834 | 19,538 | 2,325 | 4,921 | 43,618 |
| | (39%) | (45%) | (5%) | (11%) | (100%) |

Case Finding Costs (per family contact)
(Case Finding Aides)

| Period | No. Family Contacts | Case Finding Costs | Costs per Contact |
|---|---|---|---|
| February | 97 | $3,335 | $34.38 |
| March | 79 | 3,335 | 42.22 |
| April | 34 | 3,388 | 99.64 |
| May | 86 | 3,388 | 39.40 |
| June | 104 | 3,388 | 32.58 |
| | 400 | 16,834 | 49.64 Avg. cost per contact |
| | | | 37.15 Avg. cost per contact, excluding April |

Show for Screen Costs
(Case Finding Aides)

| Period | No. of Shows For Screens | Case Finding Costs | Costs per Show for Screen |
|---|---|---|---|
| February | 132 | $3,335 | $25.27 |
| March | 91 | 3,335 | 36.65 |
| | | $6,670 | |

THESE DATA ARE PRESENTED ONLY TO INDICATE THE POTENTIALITIES OF THE SYSTEM WHEN IN "FULL CYCLE". THESE DATA MUST NOT BE CONSIDERED REPRESENTATIVE OF THE PROJECT ACTIVITIES.

Based upon other projects evaluated by the HSRI, a planning figure for estimating case finding costs was established at $22 per show for screen (1974 dollars)[1]. Assuming a 15% cost of living increase in the Dallas area over the past two years, this would equate to $25.30 for 1976. The February cost per show for screen of $25.27 would appear to be "on the mark", however several factors must be considered:

(1) This was the first month of operations and in no way should be considered representative.

(2) Transportation of clients was not included in the costs (Feb-May).

(3) This represented 100% face-to-face effort, whereas the $22 planning figure was based on more of a composite type case finding approach.

Case Monitoring Costs

Cost per Problem Completed

Cost per Case Completion

Cost per Immunization Completion

Cost per Screen Completion

The data collection had not gone "full cycle" in this subsystem at the end of this report period; therefore, these data will not be reported until Report No. 2.

---

[1] EPSDT Demonstration Projects: An Interim Evaluation, April, 1974 - March, 1975, HSRI - January, 1976.

# Chapter V

# THE DATA SYSTEM

## General

Information must be gathered on the clients of EPSDT at various points of encounter in the EPSDT process in order to obtain the data necessary to describe the program. The information is obtained by having service personnel who come in direct contact with the client complete special data forms. Due to the volume of forms involved in a project the size of the one in Dallas, it would take a monumental effort with a high manpower requirement to manually compile the data from these forms in a manner that would be useful in evaluating the project. Thus, for a project of this scope, it becomes expedient to use an automated data processing system for the storage and retrieval of data. This chapter deals with all aspects of gathering data and utilizing an automated information system to perform an analysis.

## Data Collection Forms

The basic components of this information system are the various data collection forms. There are four forms used to obtain data about clients in the Dallas project. These are the Family Contact Form, the Project Data EPSDT Screening Sheet, the Immunization Annex, and the EPSDT Medical Referral/Case Monitoring Sheet set. Based upon the variables proposed for testing (grant proposal) and other basic information, a list of data elements essential to the research was drawn up. From these lists and the experience gained from the use of forms in other projects, a set of forms was drafted. These forms were pretested at the project and then revised, using feedback from the pretest. Following the revisions, the forms were taken to a printer to be produced in quantity. Copies of the forms may be found in Appendix 1.

## Forms Distribution

Prior to printing the forms it was necessary to conceptualize how the information requested would be obtained and then disseminated, i.e., who needed copies of forms. In order to visualize the process involved in completing the forms, a set of flow diagrams was developed (See Appendix 2). Using the diagrams as a stepping stone to more completely understand the data collection process, a set of instructions for the use of each form was drawn up. A complete set of instructions can be found in Appendix 3.

From examination of the flow diagrams, it is apparent that they all end at the point where the On-site Data Coordinator transmits the appropriate copies to the HSRI. The remainder of this chapter will concentrate on what takes place once the forms are received at the HSRI.

## Systems Equipment (Hardware)

As mentioned in the opening paragraph, an automated data system is used to process the information. The HSRI is set up for remote entry to an IBM 370/158

computer located at San Antonio College (SAC). The computer has two megabytes of main memory running under VM/370. A brief description of the release of VM/370 implemented at SAC is found in Appendix 4. HSRI is linked to SAC via a leased phone line which supports a 3755 RJE (remote job entry) station and three 3277 display terminals (T.V.-like). Figure 1 (page 49 ) shows the communication links between the equipment that is available to the HSRI.

In terms of input of project data, the system currently uses one of the 3277 display terminals. An operator enters data through this terminal running under the control of CICS programs. CICS is a programming language and system similar to that used by the airlines for on-line entry and retrieval. A terminal operator can enter approximately 500 documents (forms) per day. Keypunching and verification of cards is eliminated.

Software Development

By the end of the report period (June 30) programs were operational for the Family Contact and Project Screening systems. Both systems allow for entry, update, and inquiry. Yet to be included are programs allowing the operator to change information on a case once it is already on file. The systems are constructed in such a way as to require a minimum of effort on the part of the operator. The CICS programs only allow entries in specific fields on the screen, thus reducing the change of error and enhancing the speed of entry. Data entered under CICS control is stored as ISAM files on 3330 disks.

Data Access and Analysis

There are two primary means by which the researcher may access the information once it is entered and stored. One is by the inquiry method, which is accomplished by entering a specific client's number, and in the screening system, one additional element of identifying information. The record for that client is then automatically displayed on the screen. This method will retrieve only one case at a time and is generally used to pinpoint errors or to find very specific information. The other method by which the researcher accesses the data is through the pre-programmed statistical package SPSS (Statistical Package for the Social Sciences). Since SPSS works only on sequential files, a routine is executed to produce a sequential file from the on-line ISAM file. Through SPSS the researcher is able to look at either a single variable or multiple variables for the total cases on the file or any defined subset. A wide range of statistical procedures are available ranging from simple frequencies to factorial analysis. It is through the use of SPSS that the rates are obtained and compared in order to test the hypotheses on which the demonstration is based.

The SPSS programs are written under the control of the CMS operating system, a versatile system allowing direct entry of program code via a display terminal, or the 3767 typewriter terminal. Once a program is written, it is transferred to the VS 1 operating system for execution. The output is received at the RJE Station printer.

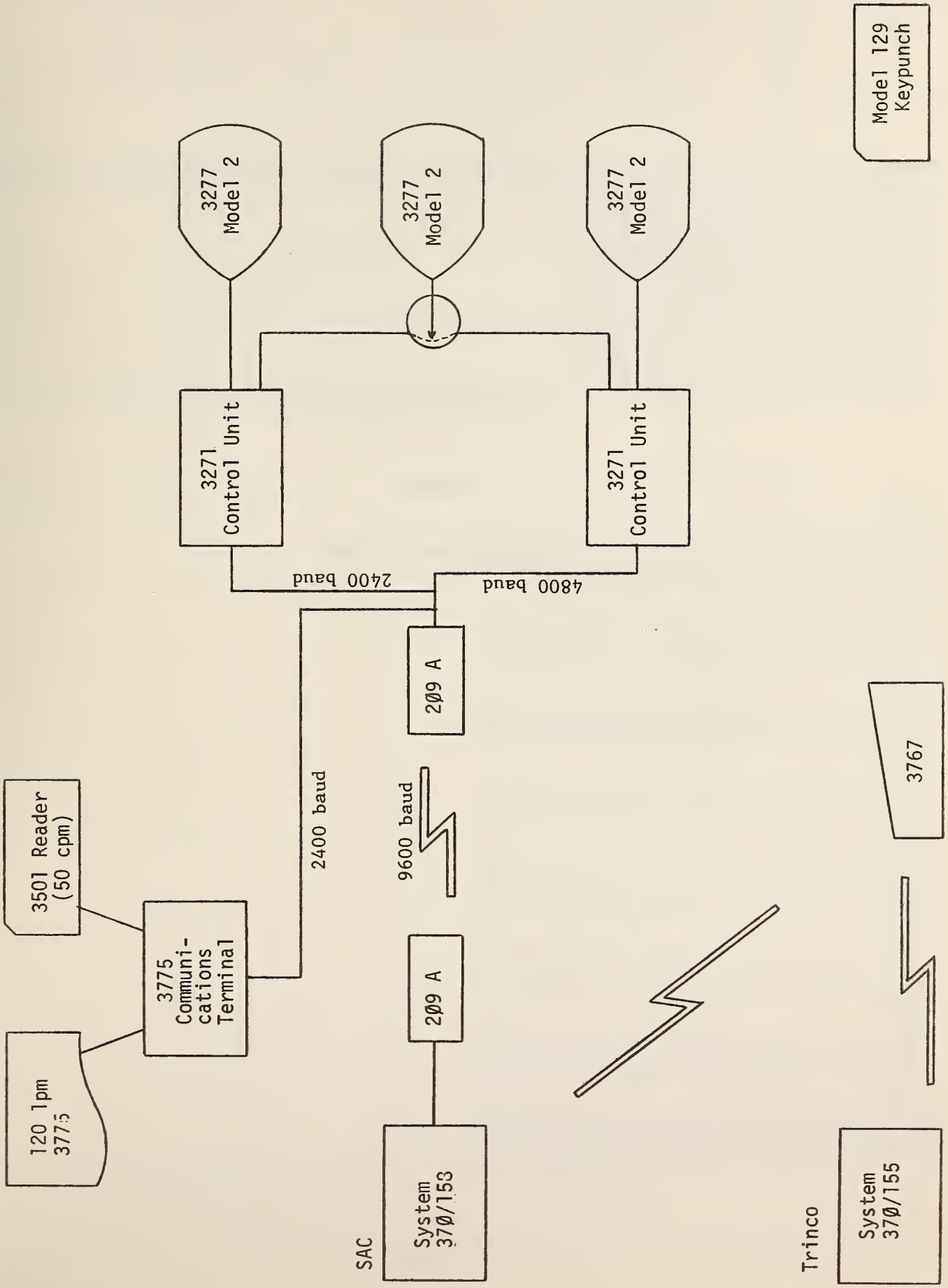
State Provided Lists of Program Eligibles

Also used in the analysis process are tapes of EPSDT eligibles sent each month from the Texas DPW data processing center. These tapes must be physically carried to SAC but the programs run against them are entered from the HSRI. The tapes are necessary in determining the penetration rates in the project.

Full Cycle Data System

One other task for which the automated system is used is the production of monthly management rosters. These are lists of project data forms which have not been completed after a prescribed period of time. In this report period rosters were produced in the first week of June for those Family Contact Forms and Project Data Screening Sheets that were initiated in February but not yet completed (See page 21). The project personnal are given 90 days to complete these two forms before they appear on the printout. Then they are given 21 days to complete actions indicated by the roster. This is a tool used to avoid forms being neglected or lost over the course of the project. This purpose was successfully achieved in this first report period.

Figure 1
HSRI DATA PROCESSING HARDWARE CONFIGURATION



# Appendix 1

## Data Collection Forms

State of Texas
Department of Public Welfare

51

Form T-405
January 1976

# EPSDT FAMILY CONTACT FORM

Head of Household Medicaid No.

Date of Contact (Mo. Day Yr.)

Casefinder

Head of Household Name, Last

First

Sector

Address

ZIP

Phone

**Ethnicity**

- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other _____ _____ 5 ☐

**Outcome of Contact**

- Willing to Participate 1 ☐
- Unable to Locate Family 2 ☐
- Refused to Participate 3 ☐
- Screened in Another Program 4 ☐
- Other _____ 5 ☐

## ELIGIBLES IN HOUSEHOLD

| | No. | Name | Age | Sex | | Date for Screen | Appmt. Time | ✓ if Trans. Req'd. | Screen Location |
|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 1 | | | | |
| 2 | | | | | 1 | | | | |
| 3 | | | | | 1 | | | | |
| 4 | | | | | 1 | | | | |
| 5 | | | | | 1 | | | | |
| 6 | | | | | 1 | | | | |
| 7 | | | | | 1 | | | | |
| 8 | | | | | 1 | | | | |

More than 8 children in family? ☐ Yes — If yes, initiate second sheet and staple together.

Name of Casefinder _____ Head of Household _____

HSRI

State of Texas
Department of Public Welfare

Form T-405
January 1976

# EPSDT FAMILY CONTACT FORM

Head of Household Medicaid No.

Date of Contact (Mo. Day Yr.)

Casefinder

Head of Household Name, Last

First

Sector

Address

ZIP

Phone

**Ethnicity**

- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other _____ _____ 5 ☐

**Outcome of Contact**

- Willing to Participate 1 ☐
- Unable to Locate Family 2 ☐
- Refused to Participate 3 ☐
- Screened in Another Program 4 ☐
- Other _____ 5 ☐

**Reasons for No Show at Screen**

- Family Moved 1 ☐
- Family No Longer Eligible 2 ☐
- Refuses to Make Another Appmt. 3 ☐
- Unable to Contact After Numerous Efforts 4 ☐
- Repeated Appmt. Failures 5 ☐
- Other _____ 6 ☐

## ELIGIBLES IN HOUSEHOLD

| | No. | Name | Age | Sex | | Date for Screen | Appmt. Time | ✓ if Trans. Req'd. | Screen Location | ✓ if Appmt. Kept | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 2 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 3 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 4 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 5 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 6 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 7 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |
| 8 | | | | | 1 | | | | | | 1 |
| | | | | | 2 | | | | | | 2 |
| | | | | | 3 | | | | | | 3 |

More than 8 children in family? ☐ Yes — If yes, initiate second sheet and staple together.

Name of Casefinder _____ Head of Household _____

PROJECT

State of Texas
Department of Public Welfare

Form T-406
January 1976

# PROJECT DATA
# EPSDT SCREENING SHEET

Medicaid No. or Client No.

Date ___ Mo. ___ Day ___ Yr.

Name ___ Last ___ First ___ M.I.

Sex M ☐ F ☐

Birthdate ___ Mo. ___ Day ___ Yr.

**Ethnicity**

- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other _____ 5 ☐

**Screening Site**

- Oak Cliff 1 ☐
- Swiss Ave. 2 ☐
- Martin L. King 3 ☐
- Lion's Club 4 ☐
- Other _____ 5 ☐

Case Monitor Code ___

Sector ___

Length of time at current address _____ Yrs. _____ Mos.

Length of time on Medicaid _____ Yrs. _____ Mos.

**Transportation to Clinic**

- Drove Self 1 ☐
- Free Taxi 2 ☐
- Brought by Welfare Staff 3 ☐
- Rode with Friend/Relation 4 ☐
- Walked 5 ☐
- Rode Bus/Taxi (Pub. Trans.) 6 ☐
- Rode Welfare Vehicle 7 ☐
- Other Specify _____ 8 ☐

**Referred by** (Check main factor)

- Newspaper ad 1 ☐
- Radio notice 2 ☐
- T.V. notice 3 ☐
- School 4 ☐
- Letter notice 5 ☐
- Walk-in 6 ☐
- Home visit (Casefinder) 7 ☐
- Phone call (Casefinder) 8 ☐
- Neighbor 9 ☐
- Other Specify _____ 10 ☐

**Medical Care During Past 12 Months**

No Contacts ☐

| | Number of: Check-ups | | Number of: Sick Visits |
|---|---|---|---|
| Private physician | ☐ | 1 | ☐ |
| Outpatient Clinic | ☐ | 2 | ☐ |
| Hosp. Emergency Room | | 3 | ☐ |
| Hosp. (inpatient) Adm. | | 4 | ☐ |
| Dentist | ☐ | 5 | ☐ |
| Optometrist/Ophthal. | ☐ | 6 | ☐ |
| School Physical | ☐ | 7 | ☐ |
| Other _____ | ☐ | 8 | ☐ |

**Screening Sequence**

- Original EPSDT ☐
- Periodic Rescreen ☐

Date for Rescreen ___ Mo. ___ Day ___ Yr.

Visit Number: 1 2 3 4

State of Texas
Department of Public Welfare

Form T-406
January 1976

# PROJECT DATA
# EPSDT SCREENING SHEET

Medicaid No. or Client No. ☐ ☐☐☐☐☐☐ ☐☐

Date ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ (Last) ☐☐☐☐☐☐☐☐☐☐ (First) ☐ (M.I.)

Sex M ☐ F ☐

Birthdate ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

**Ethnicity**
- Black 1 ☐
- White 2 ☐
- Spanish Surname 3 ☐
- American Indian 4 ☐
- All Other _____ 5 ☐

**Screening Site**
- Oak Cliff 1 ☐
- Swiss Ave. 2 ☐
- Martin L. King 3 ☐
- Lion's Club 4 ☐
- Other _____ 5 ☐

Case Monitor Code ☐☐☐

Sector ☐☐

Length of time at current address _____ Yrs. _____ Mos.

Length of time on Medicaid _____ Yrs. _____ Mos.

**Transportation to Clinic**
- Drove Self 1 ☐
- Free Taxi 2 ☐
- Brought by Welfare Staff 3 ☐
- Rode with Friend/Relation 4 ☐
- Walked 5 ☐
- Rode Bus/Taxi (Pub. Trans.) 6 ☐
- Rode Welfare Vehicle 7 ☐
- Other Specify _____ 8 ☐

**Referred by** (Check main factor)
- Newspaper ad 1 ☐
- Radio notice 2 ☐
- T.V. notice 3 ☐
- School 4 ☐
- Letter notice 5 ☐
- Walk-in 6 ☐
- Home visit (Casefinder) 7 ☐
- Phone call (Casefinder) 8 ☐
- Neighbor 9 ☐
- Other Specify _____ 10 ☐

**Medical Care During Past 12 Months**

No Contacts ☐

| | Number of: Check-ups | Sick Visits | | Number of: Check-ups | Sick Visits |
|---|---|---|---|---|---|
| Private physician | ☐ | 1 ☐ | Dentist | ☐ | 5 ☐ |
| Outpatient Clinic | ☐ | 2 ☐ | Optometrist/Ophthal. | ☐ | 6 ☐ |
| Hosp. Emergency Room | | 3 ☐ | School Physical | ☐ | 7 ☐ |
| Hosp. (inpatient) Adm. | | 4 ☐ | Other _____ | ☐ | 8 ☐ |

**Screening Sequence**
- Original EPSDT ☐
- Periodic Rescreen ☐

Date for Rescreen ☐☐ ☐☐ ☐☐ (Mo. Day Yr.)

Visit Number: 1 2 3 4

Healthiness Rating ☐

**TESTS AND MEASUREMENTS**

| | | Req. | Result: Normal | Result: Abn. | Retest |
|---|---|---|---|---|---|
| 1 | T.B. Mantoux | | | | |
| 2 | Vision Test | | | | |
| 3 | Hearing Test | | | | |
| 4 | Development (DDST) | | | | |
| 5 | Urinalysis | | | | |
| 6 | Hemoglobin | | | | |
| 7 | Hemoglobinopathies | | | | |
| 8 | Lead | | | | |
| 9 | PKU | | | | |
| 10 | RPR | | | | |

Total Problem Sheets Initiated ▶ ☐

Staff Code of Primary Screener ☐☐☐

Screening Now Complete? Yes ☐

**Reasons for inability to Complete Screen**
- Family moved 1 ☐
- Family no longer eligible 2 ☐
- Refuses to make another appmt. 3 ☐
- Unable to contact after numberous efforts 4 ☐
- Repeated appmt. failures 5 ☐
- Other _____ 6 ☐

CASE MONITOR

State of Texas
Department of Public Welfare

53

Form T-407
January 1976

# IMMUNIZATION ANNEX

Medicaid No. or Client No.

Date ___ Mo. ___ Day ___ Yr.

Name ___ Last ___ First ___ M.I.

Sex M ☐ F ☐

Age ___ Yrs. ___ Mos.

Case Monitor Code ___

Sector ___

| IMMUNIZATIONS | AGE AT SCREENING | | | | | | | CURRENT STATUS | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Routinely required for child this age? | Has child had this immunization—including this visit? | | Subsequent immunizations—current series (within 4 months of this visit) only. | |
| | 2-4 Mos. | 4-6 Mos. | 6-11 Mos. | 12-17 Mos. | 1 1/2-5 Yrs. | 6-13 Yrs. | 14-21 Yrs. | ✓ If Req'd. | Enter Date Received | | Date Required | Date Received |
| DPT #1 | | | | | | | | 1 | | | | |
| TOPV #1 | | | | | | | | 2 | | | | |
| DPT #2 | | | | | | | | 3 | | | | |
| TOPV #2 | | | | | | | | 4 | | | | |
| DPT #3 | | | | | | | | 5 | | | | |
| TOPV #3 | | | | | | | | 6 | | | | |
| MEASLES | | | | | | | | 7 | | | | |
| RUBELLA | | | | | | | | 8 | | | | |
| MUMPS | | | | | | | | 9 | | | | |
| DPT after age 18 mos. (#3 or 4) | | | | | | — | — | 10 | | | | |
| TOPV after age 18 mos. (#3 or 4) | | | | | | — | — | 11 | | | | |
| DPT after age 4 yrs. (#3, 4, or 5) (Td if given after age 6) | | | | | | | — | 12 | | | | |
| TOPV after age 4 yrs. (#3, 4, or 5) | | | | | | | | 13 | | | | |
| Td within last 10 yrs. | | | | | | | | 14 | | | | |

**KEY**

DPT Diptheria and tetanus toxoids combined with pertussis vaccine

TOPV Trivalent oral polio vaccine

Td Combined tetanus and diphtheria toxoid (Adult Type).

☐ DO AT THIS AGE

■ DO AT THIS AGE ONLY IF NOT DONE AT PREVIOUSLY SCHEDULED AGE

*Enter "Date Required" only for immunizations to complete a current ongoing series such as DPT or TPOV. According to the schedules on this page no such date should be later than 4 mos. of the current visit or an entry in the column "has child has his immunization?" Accordingly immunizations will be considered current only if there is an entry under "Enter Date Received" for each immunization (✓) checked as required or there is an entry under "Date Received" matching any entry under "Date Required" under the overall heading "Subsequent immunizations - current series only."

| SCHEDULE FOR IMMUNIZATIONS INITIATED IN INFANCY | |
|---|---|
| AGE | VACCINES |
| 2 Mos. | DPT #1, TOPV #1 |
| 4 Mos. | DPT #2, TOPV #2 |
| 6 Mos. | DPT #3, TOPV #3 |
| 12 Mos. | Measles, Rubella, Mumps |
| 18 Mos. | DPT #4, TOPV #4 |
| 4-6 Yrs. | DPT #5, TOPV #5 |
| 14-16 Yrs. | Td (continue every 10 yrs.) |

| SCHEDULE FOR IMMUNIATIONS INITIATED AFTER AGE ONE | | |
|---|---|---|
| TIME INTERVAL | 1–5 YRS. | 6 YRS. and OLDER |
| First visit | DPT #1- TOPV #1 | Td (1st)- TOPV (1st) |
| 1 Mo. Later | Measles, Rubella, Mumps | Measles, Rubella,*Mumps |
| 2 Mos. Later | DPT #2- TOPV #2 | Td (2nd)- TOPV (2nd) |
| 4 Mos. Later | DPT #3- TOPV #3 | — |
| 6-12 Mos. Later | DPT #4, TOPV #4 | Td (3rd)- TOPV (3rd) |
| At age 14-16 Yrs. | Td (every 10 yrs.) | Td (every 10 yrs.) |

*Rubella Vaccine should not be given to a post-menarchal girl without physician consultation.

TDHR-DPW
Form 402
May 1976

# EPSDT
# EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
# MEDICAL REFERRAL

## I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

1. PATIENT'S DPW NO.
2. CASE NAME (PAYEE)
3. REFERRAL NO.
4. PATIENT'S NAME (LAST, FIRST, MIDDLE)
5. BIRTH DATE
6. ADDRESS (STREET, CITY, STATE, ZIP)
PHONE NO.
7. DPW WORKER/AGENCY REPRESENTATIVE
DPW WORKER BJN/ AGENCY NAME & ADDRESS
WORKER PHONE NO.

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP):
PHYSICIAN PHONE NO.
9. APPOINTMENT TIME
DAY
DATE
10. RESCHEDULED APPOINTMENTS

## II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

2. SCREEN DATE

3. REASON FOR REFERRAL:

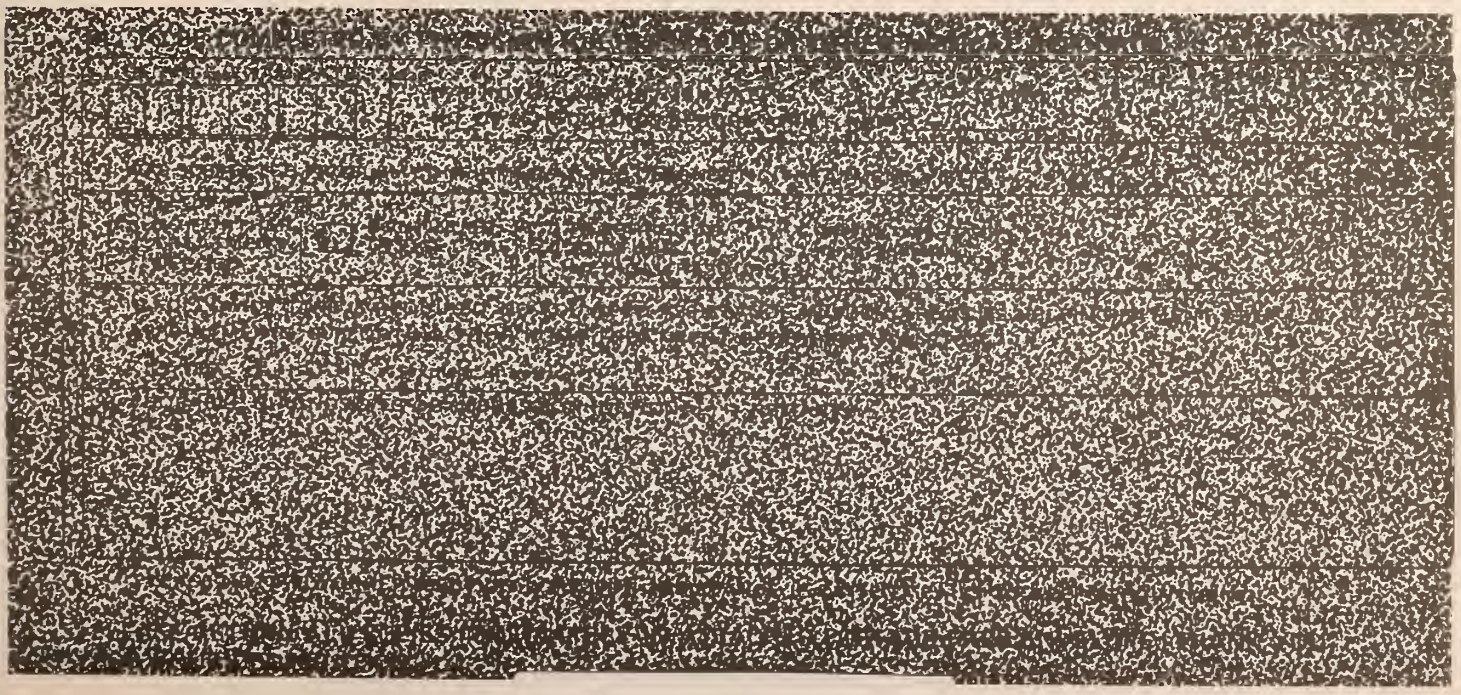
4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN

SIGNATURE DATE



EPSDT Regional Coordinator

TDHR-DPW
Form 402-1
May 1976

# EPSDT
# EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
# MEDICAL REFERRAL

## I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

1. PATIENT'S DPW NO.
2. CASE NAME (PAYEE)
3. REFERRAL NO.
4. PATIENT'S NAME (LAST, FIRST, MIDDLE)
5. BIRTH DATE
6. ADDRESS (STREET, CITY, STATE, ZIP)
PHONE NO.
7. DPW WORKER/AGENCY REPRESENTATIVE
DPW WORKER BJN/ AGENCY NAME & ADDRESS
WORKER PHONE NO.

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP):
PHYSICIAN PHONE NO.
9. APPOINTMENT TIME
DAY
DATE
10. RESCHEDULED APPOINTMENTS

## II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.

DEAR DOCTOR

THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON
AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

2. SCREEN DATE

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN
SIGNATURE DATE

## III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE
2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) – REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE-FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

Health Provider

TDHR-DPW
Form 402-1
May 1976

# EPSDT
# EARLY PERIODIC SCREENING DIAGNOSIS AND TREATMENT
# MEDICAL REFERRAL

## I. TO BE COMPLETED BY DPW OR CONTRACTING AGENCY

CASE INFO.

1. PATIENT'S DPW NO.
2. CASE NAME (PAYEE)
3. REFERRAL NO.
4. PATIENT'S NAME (LAST, FIRST, MIDDLE)
5. BIRTH DATE
6. ADDRESS (STREET, CITY, STATE, ZIP)
PHONE NO.
7. DPW WORKER/AGENCY REPRESENTATIVE
DPW WORKER BJN/ AGENCY NAME & ADDRESS
WORKER PHONE NO.

CLIENT INFO.

8. REFERRED TO (PHYSICIAN'S NAME, ADDRESS, ZIP):
PHYSICIAN PHONE NO.
9. APPOINTMENT TIME
DAY
DATE
10. RESCHEDULED APPOINTMENTS

## II. TO BE COMPLETED BY SCREENING PROVIDER

PROVIDER INFORMATION AND TDHR CLINIC REPORT

1. TDHR PROVIDER NO.
2. SCREEN DATE

DEAR DOCTOR
THE ABOVE CHILD WAS SCREENED BY THE TEXAS DEPT. OF HEALTH RESOURCES ON AND A PROBLEM IS SUSPECTED AS SHOWN BELOW.

3. REASON FOR REFERRAL:

4. REFERRAL DATE

5. PROBLEM HISTORY: ☐ COMPLETELY NEW CONDITION PREVIOUSLY KNOWN, ☐ NOT UNDER CARE ☐ UNDER CARE

6. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION ON THE ABOVE NAMED INDIVIDUAL TO THE TEXAS DEPARTMENT OF PUBLIC WELFARE AND THE TEXAS DEPARTMENT OF HEALTH RESOURCES.

SIGNATURE OF PARENT OR GUARDIAN
SIGNATURE DATE

## III. TO BE COMPLETED BY PHYSICIAN (OR HIS STAFF) OR OTHER MEDICAL RESOURCE

PROVIDER REPORT TO DPW

1. SERVICE/EXAM DATE
2. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO*
NO. OF SCHEDULINGS BEFORE APPMT. KEPT? _____

3. WAS SUSPECTED PROBLEM CONFIRMED AT THE DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

4. FOLLOW-UP CARE
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED TO ANOTHER MEDICAL RESOURCE (specify type, name, address)

5. IF FOLLOW-UP CARE IS REQUIRED, DO YOU NEED ASSISTANCE IN SUCH AREAS AS HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING YOUR HOME TREATMENT REQUIREMENTS, ETC.?
☐ YES ☐ NO (explain, if yes)

6. PROBABLE DIAGNOSIS/ES OR IMPRESSION (OPTIONAL) — REMARKS:

* PLEASE NOTIFY WORKER (SECTION I, #7) FOR ASSISTANCE IF PATIENT FAILS TO KEEP APPOINTMENT.

PLEASE RETURN ALL COPIES IMMEDIATELY IN ATTACHED POSTAGE FREE ENVELOPE. THANK YOU FOR YOUR COOPERATION.

Casemonitor → EPSDT Regional Coordinator

State of Texas
Department of Public Welfare

58

Form T-408
April 1976

# EPSDT CASE MONITORING SHEET

1. Patient's DPW No. ☐ ☐☐☐☐☐☐ ☐☐

2. Referral No. ☐☐☐☐☐☐

3. Case Monitor Code ☐☐☐

4. Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Last ☐☐☐☐☐☐☐☐☐☐ First ☐ M.I.

5. Appointment Record

| DATE | APPM'T. TIME | APPM'T. KEPT | COMMENTS |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

6. Narrative Summary of follow-up

_____

_____

_____

_____

_____

7. Problem Status (180 days after referral date or upon problem completion)
   a. Treatment completed, condition presumed cured or inactive after 1st visit ..... 1 ☐
   b. Treatment plan completed — now cured or inactive (follow-up contact) ..... 2 ☐
   c. Treatment terminated — maximum benefit achieved (not necessarily inactive or cured) ..... 3 ☐
   d. Still under treatment (original practitioner/clinic) ..... 4 ☐
   e. Still under treatment (referred practitioner/clinic) ..... 5 ☐

8. Method of follow-up
   - Mail ..... 1 ☐
   - Phone ..... 2 ☐
   - Personal contact ..... 3 ☐
   - Other
     Specify _____ 4 ☐

9. Reasons for inability to complete problem
   - Family moved ..... 1 ☐
   - Family no longer eligible ..... 2 ☐
   - Refuses to make another appmt. ..... 3 ☐
   - Unable to contact after numerous efforts ..... 4 ☐
   - Repeated appmt. failures ..... 5 ☐
   - Other
     Specify _____ 6 ☐

10. Date form completed

_____ / _____ / _____
Mo. Day Yr.

HSRI

11. DPW Worker Signature _____

TDHR-DPW
Form 402-S
May 1976

# EPSDT MEDICAL REFERRAL SUPPLEMENT

## III. FOR COMPLETION BY FOLLOW-UP WORKER

1. PATIENT'S DPW NUMBER

2. PATIENT'S NAME (LAST, FIRST, MIDDLE)

3. REFERRAL NUMBER*

4. EXAMINATION DATE

5. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT? _____

6. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

7. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED ANOTHER MEDICAL RESOURCE (specify type, name, address)

8. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ YES ☐ NO

9. DIAGNOSIS:

10. SOURCE OF DOCUMENTATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

11. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
☐ CLIENT NOT LOCATABLE
explain
☐ CLIENT NO LONGER ELIGIBLE

12. DPW WORKER/AGENCY REPRESENTATIVE

DPW WORKER BJN/AGENCY NAME AND ADDRESS

SIGNATURE

DATE

* MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION I, ITEM #3

HSRI

TDHR-DPW
Form 402-S
May 1976

# EPSDT MEDICAL REFERRAL SUPPLEMENT

## III. FOR COMPLETION BY FOLLOW-UP WORKER

1. PATIENT'S DPW NUMBER

2. PATIENT'S NAME (LAST, FIRST, MIDDLE)

3. REFERRAL NUMBER*

4. EXAMINATION DATE

5. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT? _____

6. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

7. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED ANOTHER MEDICAL RESOURCE (specify type, name, address)

8. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ YES ☐ NO

9. DIAGNOSIS

10. SOURCE OF DOCUMENTATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

11. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
☐ CLIENT NOT LOCATABLE
explain
☐ CLIENT NO LONGER ELIGIBLE

12. DPW WORKER/AGENCY REPRESENTATIVE

DPW WORKER BJN/AGENCY NAME AND ADDRESS

SIGNATURE

DATE

* MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION I, ITEM #3

EPSDT Regional Coordinator

TDHR-DPW
Form 402-S
May 1976

# EPSDT MEDICAL REFERRAL SUPPLEMENT

## III. FOR COMPLETION BY FOLLOW-UP WORKER

1. PATIENT'S DPW NUMBER

2. PATIENT'S NAME (LAST, FIRST, MIDDLE)

3. REFERRAL NUMBER*

4. EXAMINATION DATE

5. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT? _____

6. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

7. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED ANOTHER MEDICAL RESOURCE (specify type, name, address)

8. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ YES ☐ NO

9. DIAGNOSIS:

10. SOURCE OF DOCUMENTATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

11. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
☐ CLIENT NOT LOCATABLE
explain
☐ CLIENT NO LONGER ELIGIBLE

12. DPW WORKER/AGENCY REPRESENTATIVE

DPW WORKER BJN/AGENCY NAME AND ADDRESS

SIGNATURE

DATE

* MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION I, ITEM #3

Screening Site

TDHR-DPW
Form 402-S
May 1976

# EPSDT MEDICAL REFERRAL SUPPLEMENT

## III. FOR COMPLETION BY FOLLOW-UP WORKER

1. PATIENT'S DPW NUMBER

2. PATIENT'S NAME (LAST, FIRST, MIDDLE)

3. REFERRAL NUMBER*

4. EXAMINATION DATE

5. WAS INITIAL APPOINTMENT KEPT? ☐ YES ☐ NO
NO. OF SCHEDULINGS BEFORE APPOINTMENT KEPT? _____

6. WAS SUSPECTED (REFERRED) PROBLEM CONFIRMED AT DIAGNOSTIC/TREATMENT VISIT? ☐ YES ☐ NO

7. FOLLOW-UP CARE:
☐ NO FURTHER TREATMENT NEEDED
☐ CONTINUED OFFICE CARE
☐ REFERRED ANOTHER MEDICAL RESOURCE (specify type, name, address)

8. DOES PHYSICIAN REQUIRE ASSISTANCE FROM WORKER IN HELPING PATIENT KEEP APPOINTMENTS, SUPPORTING HOME TREATMENT PLANS, ETC.? ☐ YES ☐ NO

9. DIAGNOSIS:

10. SOURCE OF DOCUMENTATION: ☐ CLIENT ☐ PHYSICIAN ☐ OTHER

11. REASON FOR NON-COMPLETION OF REFERRAL-TREATMENT PROCESS:
☐ CLIENT REFUSAL
☐ SERVICE UNAVAILABLE
☐ OTHER
☐ CLIENT NOT LOCATABLE
explain
☐ CLIENT NO LONGER ELIGIBLE

12. DPW WORKER/AGENCY REPRESENTATIVE

DPW WORKER BJN/AGENCY NAME AND ADDRESS

SIGNATURE

DATE

* MUST CORRESPOND TO 402 REFERRAL NO. IN CASE RECORD, SECTION I, ITEM #3

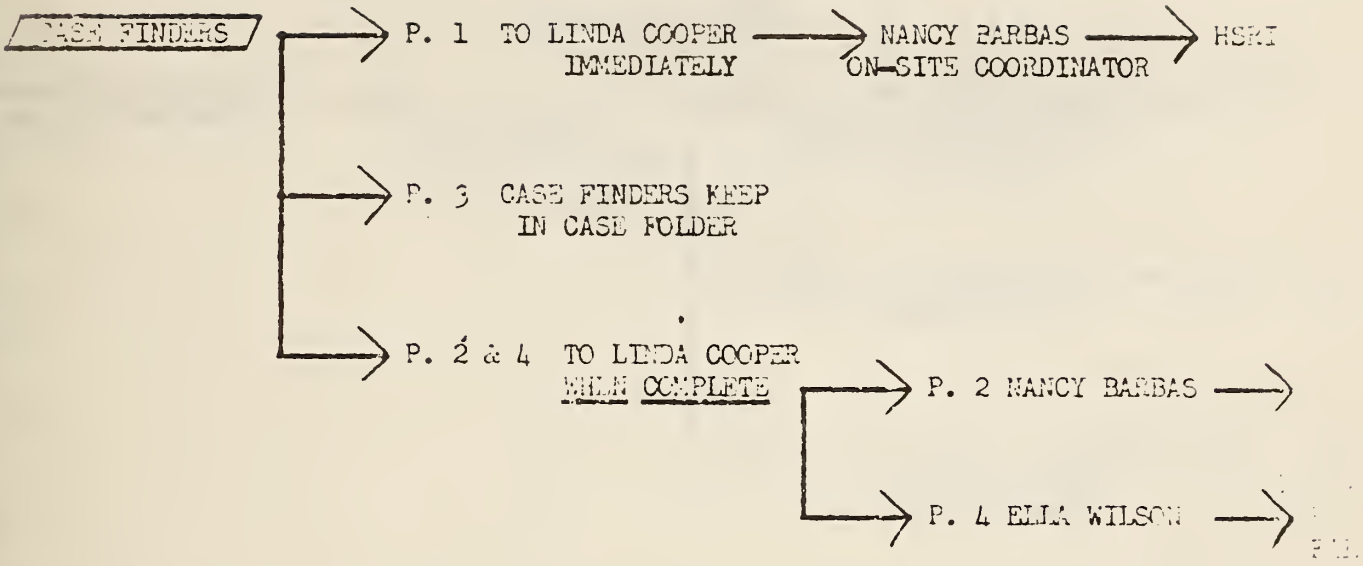
Case Record

# Appendix 2

## Form Flow Sheets

Forms Flow

Family Contact Sheet

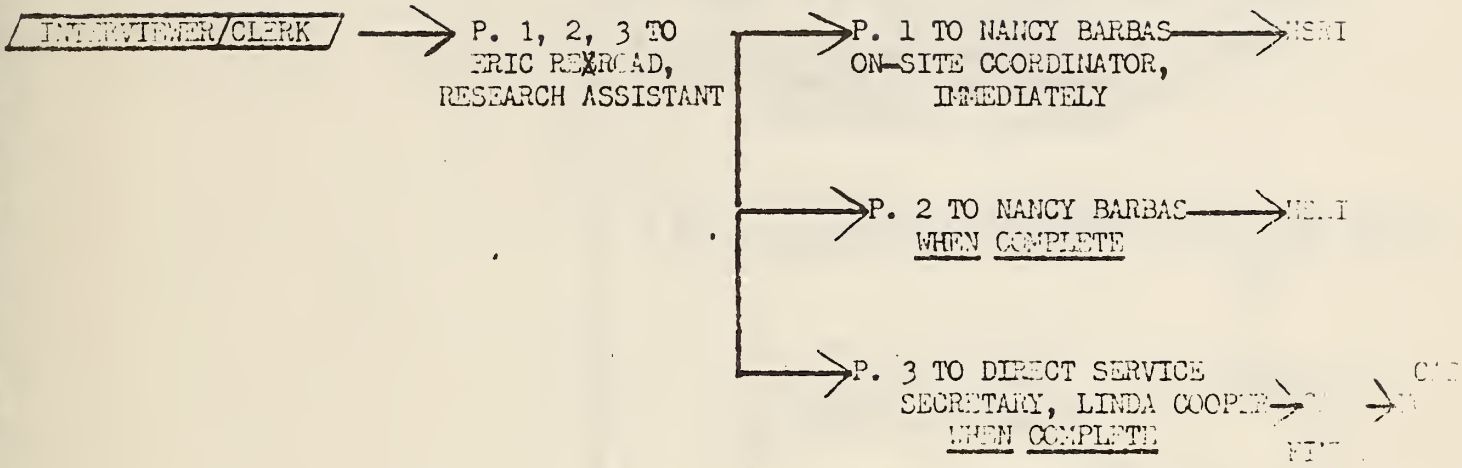



1. The Family Contact Form is orignated by the case finders for each case.
2. After the first meeting with a client when the form is orginated, page 1 is turned in to the Direct Services Secretary, Linda Cooper. * Page 1 is to be turned in within 24 hours of the client contact. Pages 2, 3, and 4 are kept by the case finders in the case folder until complete.
3. The Direct Services Secretary will check page 1 against the case finders appointment list in order to insure that a form has been turned in for each scheduled client contact. On the same day in which page 1 has been received by the Secretary, the Secretary will deliver it to the On-site Coordinator. The On-site Coordinator will send page 1 to the Health Services Research Institute.
4. Pages 2, 3 and 4 are completed after the case finder has confirmed that a screening appointment has been kept or after it is confirmed the family will not keep the appointment ( see instructions for filling out family contact form ). After completion of pages 2, 3 and 4, page 2 and 4 will be turned in to the Direct Services Secretary.*
5. The Direct Services Secretary will deliver page 2 to the On-site Coordinator who will send page 2 to the Health Services Research Institute. The Direct Services Secretary will deliver page 4 to the Statistical Clerk, Ella Wilson, who will file page 4 in the research project file.

* ( Special Instructions to Student Interns: Turn in pages as indicated in these instructions to L Vivian Graham, Assistant Project Director, rather than to the Direct Services Secretary

Forms Flow

Project Data Sheet



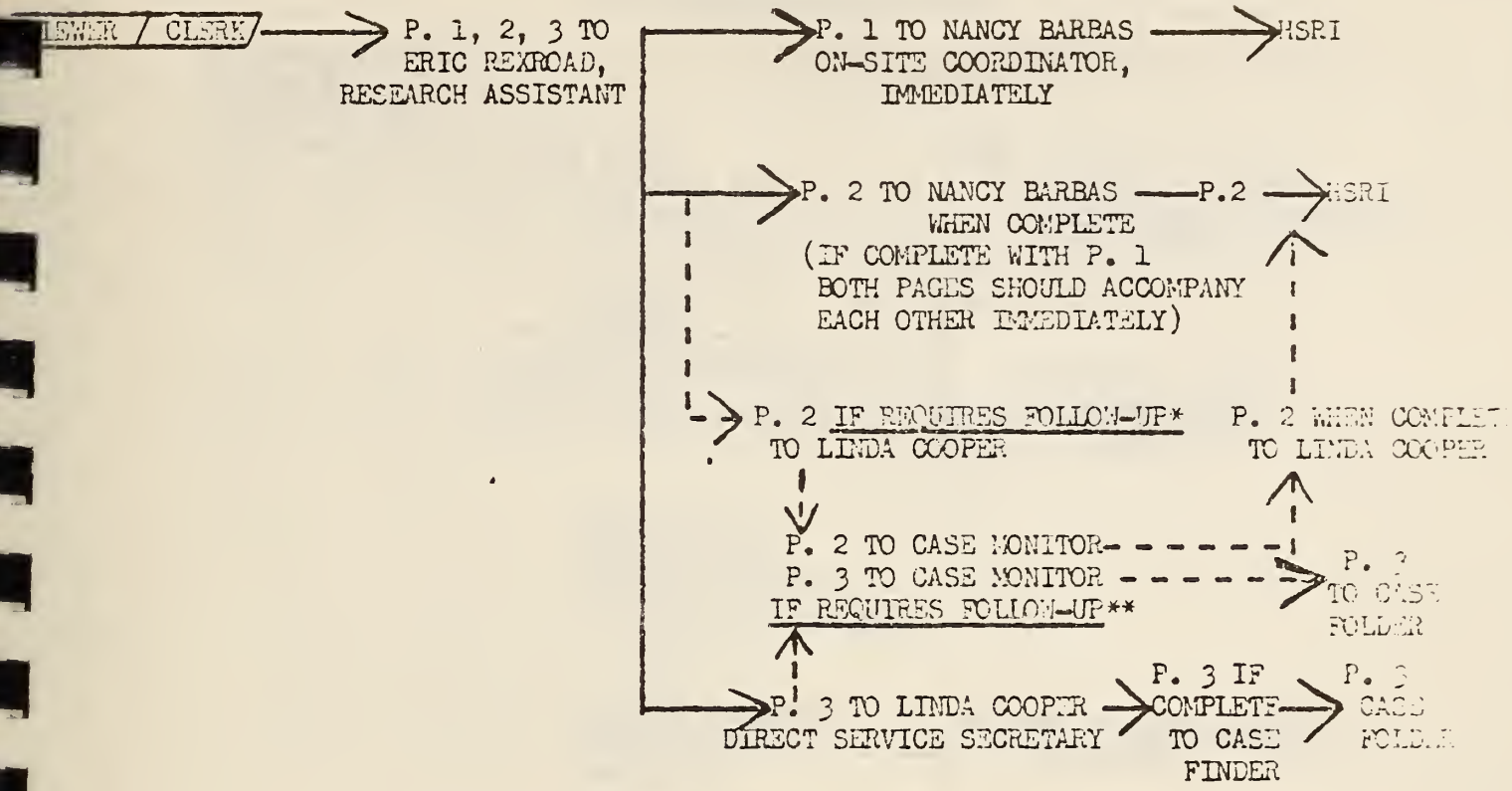

A. The Project Data Sheet is originated at the screening site by the interviewer/clerk for each child/client who is screened and lives within the demonstration area. In order to insure that a Data Sheet is completed for each patient who shows for an appointment, the interviewer/clerk will check off form completions on a clinic appointment schedule.

B. Pages 1, 2 and 3 are to be turned in to the Research Assistant, Eric Resraod, at the end of each clinic day or by the following day at the latest.

C. The Research Assistant will deliver page 1 to the On-Site Coordinator within 24 hours of receiving it, who will in turn send it to the Health Services Research Institute. The Research Assistant and / or statistical clerk will fill in the incompleted portion of the Data Sheet(page 2, 3) when the test results are received by the Health Screening Team. Upon completion , page 2 will be given to the On-Site Coordinator who will send it to the Health Services Institute.

D. Page 3 will be given by the Research Assistant to the Direct Services Secretary who will deliver it to the assigned case finder for filing in the case folder.

Immunization Annex




The Immunization Annex is originated at the screening site by the interviewer/clerk for each child/client who is screened and lives within the demonstration area.(Originate with Project Data Sheet).

Pages 1, 2, and 3 are to be turned in to the Research Assistant, Eric Rexroad, at the end of each clinic day or by the following day at the latest. (Should accompany Project Data Sheet).

The Research Assistant will deliver page 1 to the On-site Coordinator within 24 hours of receiving it, who will in turn send it to the Health Services Research Institute.

If no follow-up is necessary and the Immunization Annex is complete, page 2 will be delivered to the On-site Coordinator with page 1, who will send it to HSRI.

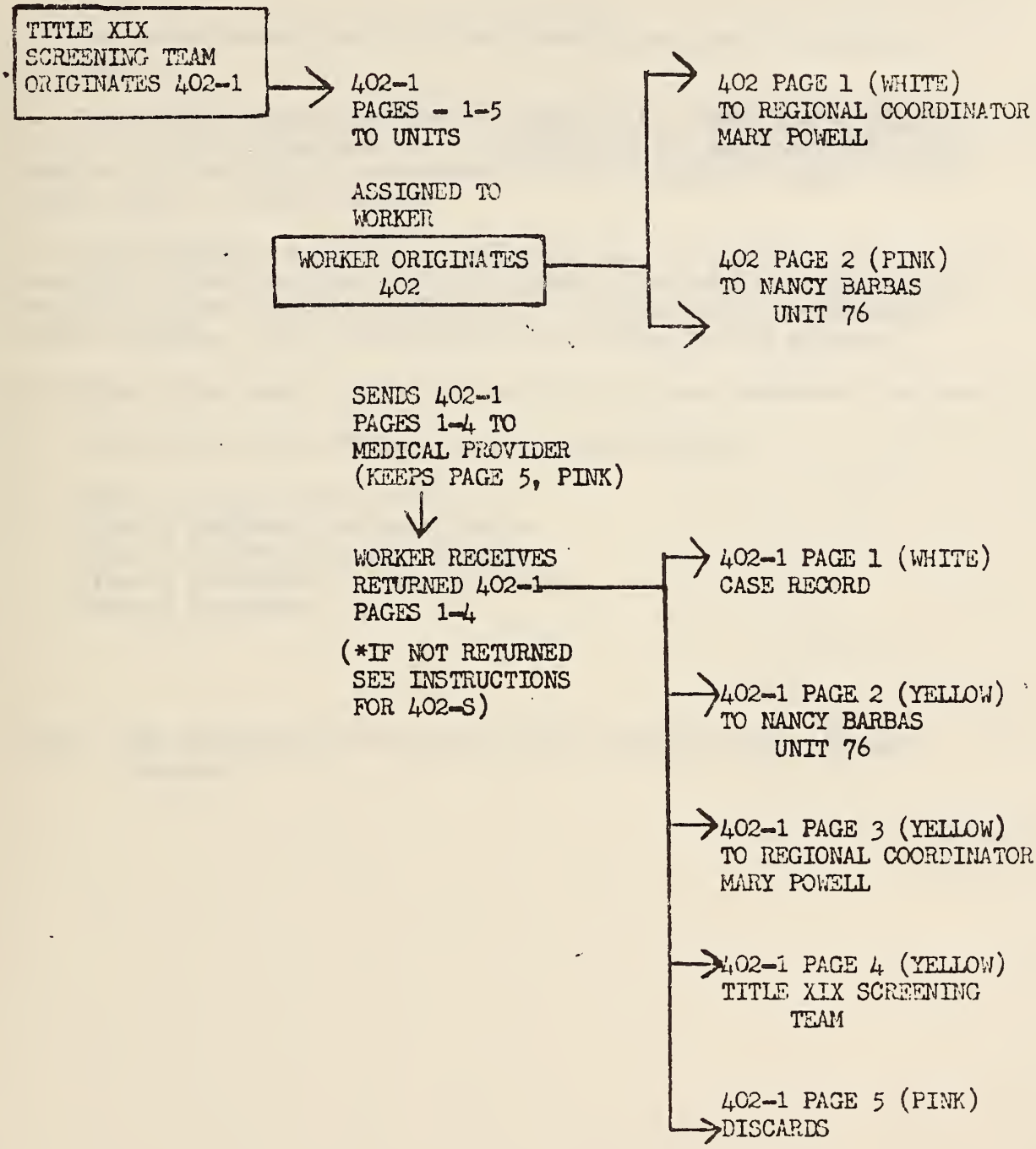
If no follow-up is necessary, the Research Assistant will deliver page 3 to the Direct Services Secretary within 24 hours of receiving it. The Secretary will deliver it to the appropriate case finder who will file it in the case folder.

If follow-up is necessary, page 2 will be delivered to the Direct Services Secretary for assignment to the appropriate case monitor. Upon completion of the Immunization follow-up the case monitor will return page 2 to the Direct Services Secretary who will deliver it to the On-site Coordinator. Page 2 will then be sent by the Coordinator to the Health Services Research Institute.

If follow-up is necessary page 3 will accompany page 2 to the Direct Services Secretary. The Secretary will deliver page 2 and page 3 to the appropriate case monitor who will complete the follow-up and then file page 3 in the case folder.

EPSDT Medical Referrel - Forms 402, 402-1

Distribution Instructions



402, 402-1

1. Form 402-1 is originated by the screening team and all pages sent to the units.

2. The assigned worker receives all pages of the 402-1 and originates F402. It is very important that the 402 be filled out accurately and completely. The 402 is distributed as soon as complete, page 1 to Mary Powell, page 2 to Nancy Barbas.

3. Upon appointing a client for follow-up care, the worker sends pages 1 thru 4 to medical provider (via the client or the mail). Accompanying the 402-1 to the provider should be a.) a postage-paid, pre addressed return envelope. b.) a pre-printed cover letter to the provider.

The worker keeps page 5 (pink) of the 402-1 for case management purposes.

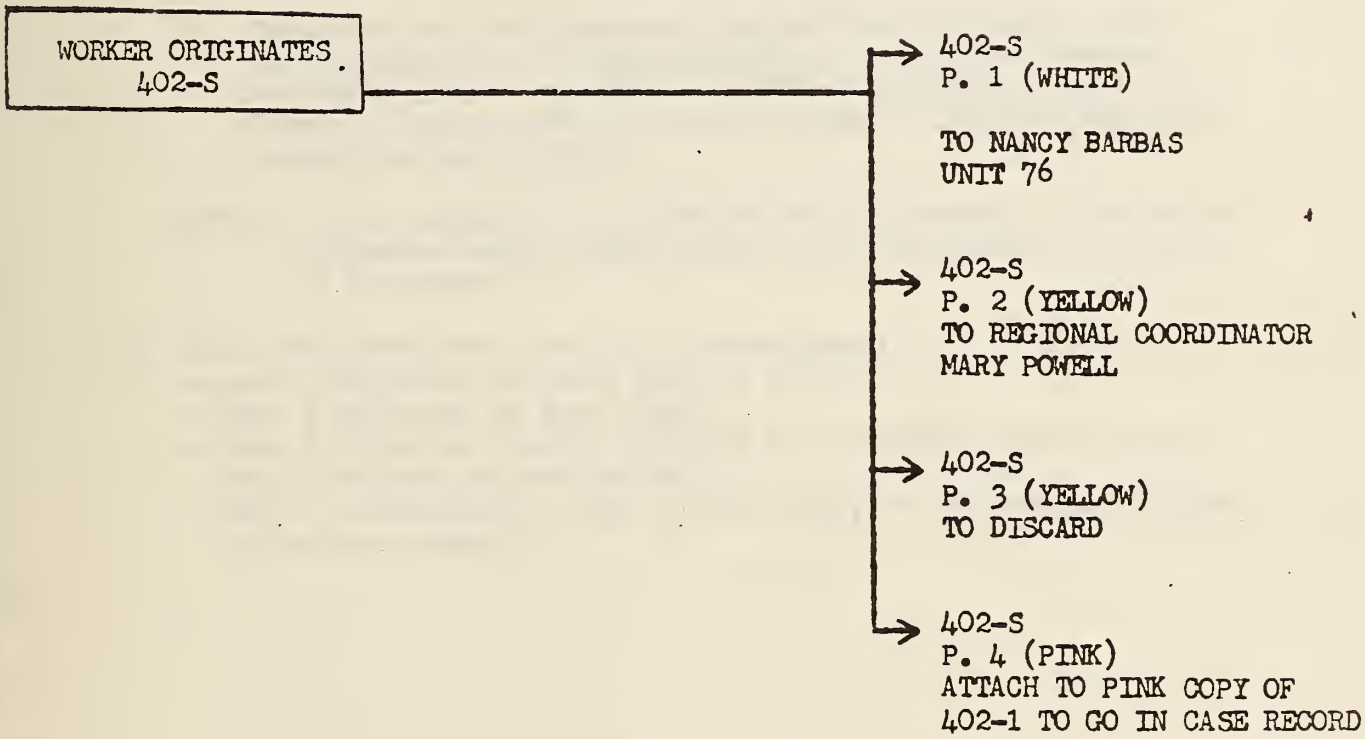
4. When pages 1-4 are returned they are distributed*:

- page 1 stays in case record
- page 2 delivered to Nancy Barbas
- page 3 delivered to Mary Powell
- page 4 delivered to screening team
- page 5 discarded

*Note: See instructions for 402-S if 402-1 not returned by Medical Provider.

EPSDT Medical Referrel - Form 402-S

Distribution Instructions



402-S

1. Form 402-S is originated by the worker if:

   a. Initiation of diagnosis/treatment has been received and the medical provider has not returned pages 1-4 of the 402-1 to the worker within three weeks of the scheduled appointment.

   b. Initiation of the diagnosis/treatment has not been received and the client is no longer eligible, has refused further services, is not locatable, or other circumstances that indicate a further need for worker follow to intitate the diagnosis/treatment process.

   NOTE: If the client has rescheduled an appointment, F402-S is not originated until three weeks of the rescheduled appointment if necessary.

2. Upon completing the 402-S it is distributed:
   - page 1 delivered to Nancy Barbas, EPSDT Unit 76
   - page 2 delivered to Mary Powell
   - page 3 discarded (Dr. Nancy White has requested that copies of the F402-S not be sent to her).
   - page 4 is attached to page 5, pink copy, of the 402-1 and filed in the case record.

CASE MONITORING SHEET FLOW

(two pages)

↓

Initiated by case monitor
simultaneously with 402-1

↓

Utilized by case monitor
in tracking case from day
of referral to day treatment
complete or end of 180 days
whichever is first

↓

copy 1 given to
on-site coordinator ⟶ to HSRI

↓

copy 2 to case record

# Appendix 3

## Instructions for Use of Forms

## EPSDT Family Contact Form

A Family Contact Form will be initiated by the case-finding aides for each personal contact (a face to face meeting with a program-eligible head of household is a contact).

1. Head of Household Medicaid No.: Enter in the spaces provided, starting from the left, e.g.,

   Head of Household Medicaid No.

   | 3 | 4 | 9 | 7 | 6 | 5 | 2 | 0 | 1 |
   |---|---|---|---|---|---|---|---|---|

2. Date of Contact: The date of contact to be entered is the date of first "eye to eye" contact with the head of household for the purpose of "selling" the EPSDT program and appointing the children for screening. Fill out the boxes numerically; for example July 4, 1976 would appear as:

   | 0 | 7 | 0 | 4 | 7 | 6 |
   |---|---|---|---|---|---|
   | Mo. | | Day | | Year | |

3. Name: Enter the last name of the head of household in the spaces provided, then the first name. It is imperative that names be spelled correctly and Medicaid numbers be entered correctly. The names in this section should be the name of the person listed on the eligibility rolls.

4. Address, Zip Code and Phone: Print the address on the line, including apartment numbers if applicable. If there is no phone, write the phone number that the head of household generally receives calls on.

5. Sector: Enter the code for "original" (1) or "periodic" (2) in the first box and the code for sector in the second box.

6. Casefinder Code: Enter your two digit code number in the boxes.

7. Ethnicity: Check the appropriate box to indicate the ethnicity of the head of household.

8. Outcome of Contact: One, and only one, of the boxes should be checked according to the outcome of the interview. If the head of household has indicated a willingness to participate in the program, efforts should be made at that point to make a specific appointment for screening for all, several, or one of the children. If the head of household consents to participate in the program, check "Willing to participate" in this section. If this box is checked, yet no dates for screen and appointment times are entered in the section under "Eligibles in household", it is assumed that the head of household did not feel free to commit to an appointment at that time.

   The system provides that at least two additional efforts should be subsequently made by telephone, personal contact, etc., to schedule the children for a screening appointment. If success in appointing is not achieved by the third contact, the case-finding aide may assume that the family declines participation and the box "Refuses to make another appointment" under the section "Reasons for no show at screen" should be checked. The family will then not again be contacted (if they remain program eligible) until the next normal periodic rescreen sequence for their ages by case-finding personnel. If the family has moved or become ineligible, check "Other" and specify the reason, then check the box that applies in the section "Reasons for no show at screen" of the second page. Staple pages 1 and 2, then forward to OSDC.

9. Reasons for No Show at Screen: This section pertains to cases in which (1) an initial face to face contact has been made, but not all of the children listed have shown for screening, (2) the family has moved away, or (3) lost eligibility. The first case applies after three attempts

at scheduling screening appointments have been made, or after 90 days from date of contact. One, and only one, of the boxes should be checked. If three appointments have been scheduled for a child or children and each has not been kept, assume that the family is not interested in participating and check the box next to "Repeated appointment failures".

10. Eligibles in Household: Enter the two-digit numbers, the names (last name first), ages and sex for all program eligible children in the household. CORRECT SPELLING OF NAMES AND AGE (in years). THIS IS VERY IMPORTANT--PLEASE PRINT.

If the head of household consents to an appointment at the time of initial interview (contact) enter the date, time and location of the appointment, check whether transportation is needed and can be provided.

EXPERIENCE IN OTHER EPSDT DEMONSTRATIONS AND ON-GOING PROGRAMS INDICATES THAT SUCCESS IN HAVING EPSDT SCREENING APPOINTMENTS KEPT DEPENDS SIGNIFICANTLY ON A MINIMAL LAPSE OF TIME BETWEEN THE DATE OF CONTACT AND THE SCREENING APPOINTMENT. THE HIGHEST RATES OF SUCCESS IN SCREENING APPOINTMENTS KEPT WERE WHERE THIS PERIOD WAS LESS THAN FIVE DAYS.

If there are more than eight children in the family, check ☐ Yes at the bottom of the form, and use another sheet to continue the list of eligible children. The Medicaid number, name, date, sector, and casefinder code should be filled out on this second sheet. Staple the two sheets together.

The column "✓ if Appmt. Kept" is used to indicate that the screening appointment has been kept. This will be determined from the appointment roster that is returned to the case finder by the clinic the day after the date of appointment.

Space is provided to allow for three appointments for each child, in the event that appointments made are not kept. If the third appointment is not kept, assume the family is not interested in participating and check the box next to "Repeated Appmt. Failures" in the section "Reasons for No Show at Screen".

11. Name of Case finder: Write your name on the line.

12. Head of Household's Signature: The head of household should sign here after being presented with the opportunity to participate in the program. A signature must be obtained whether the head of household is willing to participate or not. If the head of household refuses to participate, show him/her that you have checked the box next to "Refused to Participate" and ask that he/she sign to verify that he/she has heard the advantages of the program and refuses to participate. Obtaining a signature from a willing head of household is equally important because it further strengthens the commitment to participate and to keep appointments that have been made.

## Instructions For Filling Out Project Data Sheet

Items 1 through 9 are to be filled out at the screening site. Most of the information is obtained from the Texas DPW Screening Sheet (F400). These items should be completed before the interview.

1. Medicaid number: Copy from item #1 on F400, writing one digit per box.
2. Date: Write the screening date in the boxes, using two digits each for the month, day, and year.
3. Name: Copy the name of the person being screened from item #2 on F400, entering the last and first names and middle initial in the appropriate boxes with one letter per box.
4. Sex: Check appropriate box for sex as indicated in item #7 on F400.
5. Birthdate: Copy from item #6 on F400, one digit per box.
6. Ethnicity: Look at child's surname to determine if "Spanish Surname" is appropriate. If not, check appropriate box as indicated in item #8 on F400.
7. Screening site code: Check appropriate box. If site is other than one of the four major clinic sites, check "Other" and fill in the specific location.
8. Case monitor code: This three-digit code is broken into two parts. The first digit is an indicator of the skill level of the case monitor. The second two digits are a personal code, specifying a unique employee. Fill-in the appropriate case-monitor code according to the sector in which the client resides.

| Sector | CM Code |
|---|---|
| 01 | 111 |
| 02 | 221 |
| 03 | 331 |
| 04 | 000 |

9. Sector: The two-digit code is assigned according to the zip code and first

letter of the last name of the caretaker. The codes are as follows:

| Sector | Zip Codes | First Letter of Last Name |
|---|---|---|
| 01 | 75208<br>75203<br>75224<br>75216 | A-J |
| 02 | 75208<br>75203<br>75224<br>75216 | K-Z |
| 03 | 75215 | A-Z |
| 04 | 75223<br>75210 | A-Z |

Items 10 through 17 are questions asked of the caretaker in an interview at the screening site. Introduce yourself and explain that we are conducting a project in order to obtain information which we hope will enable us to improve the health services. Request the interviewee's help in obtaining this information, stating that you would like to ask them a few questions. Ask to see any medical and immunization records they have with them, including any received that day. Refer to these records as an aid to questions concerning medical care, health experience, and immunizations during the interview, but do not depend solely on them for a complete answer.

10. Length of time at current address: Ask: "How many years or months have you lived at your current address?" Record in the blank provided.

11. Length of time on Medicaid: Ask: "How many years or months have you currently been receiving Medicaid without a break?" If the caretaker has been on and off Medicaid, record the current consecutive length of time on Medicaid.

12. Transportation to clinic: Ask: "How did you get to the clinic today?"

"Rode bus/taxi" should be checked if the clients paid for bus, subway, or taxi fare. "Rode Welfare Vehicle" applies if the clients were transported to and from the clinic by a clinic owned vehicle. "Brought by welfare staff" should be checked if the client's caseworker or casefinder brought them. "Free taxi" will apply only to those clients in sector 01 who take advantage of the taxi transportation offered them.

13. Referred by: Ask: "What most influenced you to bring your child in for screening today?" Check appropriate box. "Home visit (casefinder)" and "Phone call (casefinder)" can apply if a caseworker or case finding aide contacted the client.

14. Medical care during past 12 months: This item identifies the place or type of medical care that the client may have had during the previous 12 months for an acute illness (sick visits) or as a preventive health measure (check-up). It is an indicator of the child's general health and the preventive health orientation of the parents. Ask: "Try to recall whether your child (you) has received any medical attention in the last year. I specifically would like to know whether he/she/you has visited:

    a doctor's private office?

    an outpatient clinic?

    a hospital emergency room?

    has been admitted into a hospital?

    a dentist?

    an eye doctor?

    had a school physical?

    any other medical provider?

(An affirmative response to any of the above categories should each be followed by:)

"How many times did you visit this health care provider? How many of these visits were made because he/she/you were feeling ill and how many visits were made as regular check-ups?" Check the box next to "No Contacts" if the child has had no medical care in the past year. Otherwise, enter the appropriate number of check-ups or sick visits in the boxes alongside each type of health care. Enter "X" in the boxes if some visits were made, but the exact number is unknown.

No Contacts ☐

| | Number of: | |
|---|---|---|
| | Check-ups | Sick Visits |
| Private Physician | ☐ | ☐ |
| Outpatient Clinic | ☐ | ☐ |
| Hospital Emergency Room | | ☐ |
| Hospital (Inpatient) Admissions | | ☐ |
| Dentist | ☐ | ☐ |
| Optometrist/Ophthalmologist | ☐ | ☐ |
| School Physical | ☐ | ☐ |
| Other (Specify)_____ | ☐ | ☐ |

15. Screening sequence: Ask: "Is this the first time your child (you) has been to a welfare-sponsored screening program?" If the child has been screened before in any EPSDT program, including another state's, check "Periodic Rescreen". Otherwise, check "Original EPSDT".

16. Date for rescreen: In accordance with the State plan for periodic rescreens, indicate in the boxes the date on which the child will be eligible for his/her periodic rescreen.

17. Visit number: Some screening completions require more than one visit. It is necessary to ascertain the impact of multi-visits on screening and case completions. Ask: "Is this the first visit your child (you) have made to the clinic for this screening or has it been necessary for you to return to complete the screen?" In this instance, circle the number that the current visit constitutes in the ongoing screening sequence. In the initial visit, the screener would have indicated "(1)". On a subsequent second visit, using the same screening sheet, the entry would appear as "(1) (2) 3 4 ", and if, for some unusual reason, a new screening sheet was initiated for this second visit, the entry would appear as " 1 (2) 3 4 ".

Thank the interviewee for his/her time and cooperation.

Items 18 through 23 (on second sheet) are completed when the results from the lab tests are available.

18. Child's healthiness rating: Write in the same number that is circled on the scale stamped on the F400.

19. Tests and measurements: Indicate which of these tests are required at this screen by placing a check in the required column. When the results of the tests are obtained, if the result is normal place a check in the normal column; if the test result is abnormal and the State does not require a retest for abnormal conditions for that test, place a check in the abnormal column. If a retest is required because of an abnormal condition found, place a check in the retest column and leave the two columns on results blank. In this case when the results of the retest are obtained, place a check in either normal or abnormal, whichever is appropriate. When this section is completed, for each check in the required column there should be

a check in either the normal or abnormal column for that test.

20. Total problem sheets initiated: Write in the box the number of problem sheets that were initiated as a result of the screening. This information is obtained by counting the number of clinic copies of problem sheets in a child's record.

21. Staff code of primary screener: The primary screener normally is the person who completes the final review of the screening sheet, determines if any of the problems require treatment, and signs the F400 at the bottom. This three-digit staff code is similar to the case monitor code in that the first digit is an indicator of a screener's qualifications and the other two digits are the screener's personal code. The following are the screening staff codes:

| | |
|---|---|
| Nancy White | 501 |
| Faye Smith | 101 |
| Susan Vaughn | 102 |
| Karen Alleman | 103 |
| Margaret Bushong | 104 |
| JoAnn Cook | 201 |
| Vora Bell | 202 |
| Betty Haywood | 203 |
| Carolyn Smith | 204 |
| Robbie Saunders | 801 |
| Jo Smith | 802 |

22. Screening complete?: It is important to identify the completion of the screening sequence. The screening is complete when the physical examination and the results of all required tests have been returned, when the child's healthiness rating has been entered, and when the staff codes for the persons completing the screening sheet have been entered. Check "Yes" when complete.

23. Reasons for inability to complete screen: This section is to be completed by the case monitor. If the screen has not been completed after the client has failed to keep three consecutive appointments, or at the end of 90 days from the date of show for screen, the case monitor should check the appropriate box.

Immunization Annex

1. Medicaid Number: Enter in the spaces provided the Medicaid number of the person being screened, e.g., [2] [3|5|6|7|0|8] [0|2]

2. Date: Enter numerically, e.g., Date [0|9|0|8|7|6]
mo. day yr.

3. Name: Print the last and first names of the person screened in the boxes provided, starting from the left in each case. If the name should contain more letters than boxes on the form, print the remainder out to the side.

4. Sex: Check the appropriate box.

5. Age: Age is included here to provide a ready reference to determine the immunization requirements for this age child generally as a base point to subsequently determine immunizations required for a particular child. Enter numerically, e.g.,

   Age [0|3|0|6] (3½ years old)
   yr. mo.

   Age [0|0|1|0] (10 months old)

6. Case Monitor Code: Fill in the boxes with the appropriate three digit code. This item is included to assign follow-up responsibility for immunizations. The first digit is an indicator of the skill level of the case monitor. The codes are as follows:

   1 - social worker (sector 01)

   2 - assistant (sector 02)

   3 - public health nurse (sector 03)

   The next two digits are unique to the employee and will be assigned upon employment.

7. Sector: The two digit code is assigned as specified in the instructions for the Project Data Sheet, and can be transcribed from that form.

6. Current Status - Routinely Required for Child this Age - Using the age and sex of the child being screened as the sole factors, simply use the appropriate age column on the form under the heading "Age at Screening" as the basis to check each box indicating requirements for specific immunizations, e.g., a child is male and

| IMMUNIZATIONS | AGE AT SCREENING | | | | | | | 7 mo. old | 4½ yr. old | 10 yr. old |
|---|---|---|---|---|---|---|---|---|---|---|
| | 2-4 Months | 4-6 Months | 6-11 Months | 12-17 Months | 1½-5 Years | 6-13 Years | 14-21 Years | Routinely required for child this age? ✓ if Required | Routinely required for child this age? ✓ if Required | Routinely required for child this age? ✓ if Required |
| DTP #1 | | | | | | | | ✓ | ✓ | ✓ |
| TOPV #1 | | | | | | | | ✓ | ✓ | ✓ |
| DTP #2 | | | | | | | | ✓ | ✓ | ✓ |
| TOPV #2 | | | | | | | | ✓ | ✓ | ✓ |
| DTP #3 | | | | | | | | ✓ | ✓ | ✓ |
| TOPV #3 | | | | | | | | ✓ | ✓ | ✓ |
| MEASLES | | | | | | | | | ✓ | ✓ |
| RUBELLA | | | | | | | | | ✓ | ✓ |
| MUMPS | | | | | | | | | ✓ | ✓ |
| DTP after age 18 months (#3 or 4) | | | | | | — | — | | ✓ | |
| TOPV after age 18 months (#3 or 4) | | | | | | — | — | | ✓ | |
| DTP after age 4 yrs. (#3,4 or 5) (Td if given after age 6) | | | | | | | — | | | ✓Td |
| TOPV after age 4 yrs. (#3,4 or 5) | | | | | | | | | | ✓ |
| Td within last 10 yrs. | | | | | | | | | | |

7. Current Status - Has Child Had this Immunization - Including Current Visit? Enter Date Received - Question the mother concerning the status of each immunization indicated as required by the previous step (paragraph 6). Immunization records kept by parents or recorded in a medical chart

can be accepted as valid. Verbal reports by parents are less valid, but can often be accepted as evidence of immunization. If the child is in school, it can be assumed that the child is up to date on immunizations since state law requires proof of immunization completeness to enter school. If exact dates of immunization are unobtainable, but the caretaker is certain that they were given, simply place a check instead of a date in the appropriate block under this column. If records are available, enter the dates of previous immunizations <u>and then record the date of those shots given at this visit</u>, if any. For example, for a child born November 1970, 3½ years old:

| IMMUNIZATIONS | AGE AT SCREENING | | | | | | | Routinely required for child this age? | Has child had this immunization - including this visit? | OR | Has child had this immunization - including this visit? |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2-4 Months | 4-6 Months | 6-11 Months | 12-17 Months | 1½-5 Years | 6-13 Years | 14-21 Years | ✓ If Required | Enter Date Received | | Enter Date Received |
| DTP #1 | | | | | | | | ✓ | Jan.71 | | 1971 |
| TOPV #1 | | | | | | | | ✓ | Jan.71 | | 1971 |
| DTP #2 | | | | | | | | ✓ | Mar.71 | | 1971 |
| TOPV #2 | | | | | | | | ✓ | Mar.71 | | 1971 |
| DTP #3 | | | | | | | | ✓ | May 71 | | Aug.7,74* |
| TOPV #3 | | | | | | | | ✓ | May 71 | | Aug.7,74* |
| MEASLES | | | | | | | | ✓ | Aug.7,74* | | |
| RUBELLA | | | | | | | | ✓ | Aug.7,74* | | |
| MUMPS | | | | | | | | ✓ | Aug.7,74* | | |
| DTP after age 18 months (#3 or 4) | | | | | | — | — | ✓ | | | |
| TOPV after age 18 months (#3 or 4) | | | | | | — | — | ✓ | | | |
| DTP after age 4 yrs. (#3,4 or 5) (Td if given after age 6) | | | | | | | — | | | | |
| TOPV after age 4 yrs. (#3,4 or 5) | | | | | | | | | | | |
| Td within last 10 yrs. | | | | | | | | | | | |

*Indicating those given at the current visit

8. <u>Current Status - Subsequent Immunizations, Current Series Only (Within Four Months of Current Visit) - Date Required</u> - This column, as well as the next one, is to be completed by the case monitor assigned to this case. Comparing the two previous steps (columns), which will have indicated the immunizations required and

those received in the past and the current visit, the action in this instance is to schedule additionally required immunizations by entering the date the next immunizations are due in the four following months; e.g.,

(Date of Birth, November 1970 - 3 1/2 years old)

| IMMUNIZATIONS | AGE AT SCREENING | | | | | | | CURRENT STATUS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Routinely required for child this age? | Has child had this immunization - including this visit? | Subsequent immunizations current series (within 4 months of this visit only) | |
| | 2-4 Months | 4-6 Months | 6-11 Months | 12-17 Months | 1½-5 Years | 6-13 Years | 14-21 Years | ✓ If Required | Enter Date Received | Date Required | Date Received |
| DTP #1 | | | | | | | | ✓ | Jan. 71 | | |
| TOPV #1 | | | | | | | | ✓ | Jan. 71 | | |
| DTP #2 | | | | | | | | ✓ | Mar. 71 | | |
| TOPV #2 | | | | | | | | ✓ | Mar. 71 | | |
| DTP #3 | | | | | | | | ✓ | May 71 | | |
| TOPV #3 | | | | | | | | ✓ | May 71 | | |
| MEASLES | | | | | | | | ✓ | Aug. 7, 74* | | |
| RUBELLA | | | | | | | | ✓ | Aug. 7, 74* | | |
| MUMPS | | | | | | | | ✓ | Aug. 7, 74* | | |
| DTP after age 18 months (#3 or 4) | | | | | | — | — | ✓ | | Oct 1, 74 | |
| TOPV after age 18 months (#3 or 4) | | | | | | — | — | ✓ | | Oct 1, 74 | |
| DTP after age 4 yrs. (#3,4 or 5) (Td if given after age 6) | | | | | | | — | | | | |
| TOPV after age 4 yrs. (#3,4 or 5) | | | | | | | | | | | |
| Td within last 10 yrs. | | | | | | | | | | | |

*Indicating those given at the current visit.

9. Current Status - Subsequent Immunizations - Current Series Only (Within Four Months of Current Visit): Date Received

Enter the date subsequently scheduled immunizations are received, e.g.,

(Date of Birth, November 1970 - 3 1/2 years old)

| IMMUNIZATIONS | AGE AT SCREENING | | | | | | | CURRENT STATUS | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | Routinely required for child's this age? | Has child had this immunization including this visit? | Subsequent immunizations current (within 6 months of this visit only) | |
| | 2-4 Months | 4-6 Months | 6-11 Months | 12-17 Months | 1½-5 Years | 6-13 Years | 14-21 Years | ✓ if Required | Enter Date Received | Date Required | Date Received |
| DTP #1 | | | | | | | | ✓ | Jan. 71 | | |
| TOPV #1 | | | | | | | | ✓ | Jan. 71 | | |
| DTP #2 | | | | | | | | ✓ | Mar. 71 | | |
| TOPV #2 | | | | | | | | ✓ | Mar. 71 | | |
| DTP #3 | | | | | | | | ✓ | May 71 | | |
| TOPV #3 | | | | | | | | ✓ | May 71 | | |
| MEASLES | | | | | | | | ✓ | Aug. 7, 74 | | |
| RUBELLA | | | | | | | | ✓ | Aug. 7, 74 | | |
| MUMPS | | | | | | | | ✓ | Aug. 7, 74 | | |
| DTP after age 18 months (#3 or 4) | | | | | | | | ✓ | | Oct 1, 74 | Oct 10, 74 |
| TOPV after age 18 months (#3 or 4) | | | | | | | | ✓ | | Oct 1, 74 | Oct 10, 74 |
| DTP after age 4 yrs (#3,4 or 5) (Td if given after age 6) | | | | | | | | | | | |
| TOPV after age 4 yrs. (#3,4 or 5) | | | | | | | | | | | |
| Td within last 10 yrs | | | | | | | | | | | |

When this step is completed and the subsequent immunizations received match those required, the child is now completely immunized for its age--the status is current. At the next rescreen in the following year for the child used in the above example, he will require two additional shots (DTP after age 4 and TOPV after age 4) to be considered completely immunized for his age.

# EPSDT MEDICAL REFERRAL

Section 1 - to be completed by DPW case monitors.

1. Patient's DPW case number - this is not the payee case number, but the person's number who has been screened and referred.
2. Case Name (payee) - enter the name of the person receiving grant (head of household).
3. Referral number - pre-stamped six-digit number.
4. Patient's Last, Middle, and First Name - enter the last name of the individual referred, then the first and middle names.
5. Birth Date - enter by digits the date of birth. Example: 07/08/75.
6. Address - Street/Route - City/Town - Zip - Phone number - enter client's address and phone number. Write sector code at end of address space.
7. DPW Worker/Agency Representative Name - print name of DPW case monitor, DPW BJN and case monitor code, and phone number. For example: Prunella Smith | 011-00-R-02-600-077-2/222 | 372-4671
8. Referred to - enter physician or appropriate medical resource's name, address, and zip code where the client is scheduled for an appointment.
9. Appointment time/day/date - enter appointment time, etc.
10. Rescheduled appointment(s) - for worker use in case record, enter new rescheduling of appointments. (See Case Monitoring Sheet for additional space.)

Section II - to be completed by screening provider.

1. TDHR provider number - enter medical screening provider number.
2. Date of screening - enter by digits (07/08/75) the date on which the client received medical screening.

3. Reason for referral - Record 400 abnormality number and explanation for medical provider. Demonstration project staff should write in major condition category code number in the space between screen date and referral date.
4. Referral date - enter by digits (07/08/75) the exact date the specified abnormality was identified and referred for diagnosis and/or treatment by the screening provider. NOTE: Except in the case of an immediate referral, the screen date and referral date will not be the same.
5. Problem History - Check one. Is the problem referred completely new to the caretaker or was it previously known and either under care or not under care.
6. Authorization for Release of Medical Information to DPW-TDHR - Appropriate person (parent or guardian) must sign and date this release. NOTE: Authorized DPW social services/personnel or the person to whom authority has been delegated should sign in the case of a foster child. The DPW worker or contracting agency representative should assist the TDHR screening provider in securing this signature.

Section III - to be completed by physician or his staff or other medical resource. NOTE: Care should be taken to include franked envelopes with the proper return address for the DPW or contracting agency worker.

1. Service or examination date - enter the date of the initial exam. NOTE: This item is very important. If the medical provider does not wish to provide the other information, he/she should enter this date and return all copies.
2. Was initial appointment kept? - Check yes or no if the client did or did

not keep the first appointment set. NOTE: This question is asterisked and refers the medical provider to the EPSDT follow-up worker for assistance if the client does not keep the first appointment.

Number of schedulings before the appointment was kept? - Enter 1 if the first appointment was kept, etc. The data generated from this item will be helpful in evaluating client response to the EPSDT program and, if the treatment is received more than 60 days after screening, will be taken into consideration on penalty regulation compliance.

3. Was the suspected problem confirmed at the diagnostic/treatment visit? - Check one. This data item will be utilized as a check on false positive screening findings.

4. Follow-up care - Check one. Was no further treatment, continued office treatment, or referral to another medical provider needed? Types of medical resources referrals include hospitalization referral, specialist referral, etc.

5. If follow-up care is required, do you need assistance in such areas as... - Check yes or no. This indicates the medical provider needs additional follow-up by the DPW worker to assist the client in following a treatment plan.

6. Probable diagnosis... - This item is optional but would provide needed information on the results of screening and treatment. If more space is required, an additional sheet of paper should be attached.

# EPSDT MEDICAL REFERRAL SUPPLEMENT

1. Patient's DPW number - enter the DPW number of the person referred from medical screening, not the payee number.
2. Patient's name - print the last, first, and middle names of the individual referred.
3. Referral number - enter by digits the exact number on the Form 402 in the case record. This item must correspond. NOTE: Complete either items 4 through 10 or item 11, based on information gathered from client and/or physician.
4. Examination date - enter the date of the initial exam. NOTE: This item is very important. If the medical provider does not wish to provide the other information, the worker should enter this date and distribute all copies appropriately.
5. Was initial appointment kept? Number of schedulings before the appointment kept? - Check appropriate box. Enter 1 if the first appointment was kept, etc. The data generated from these items will be used in evaluating client response to the EPSDT program and, if the treatment is received more than 60 days after screening, will be taken into consideration on penalty regulation compliance.
6. Was the suspected (referred) problem confirmed at diagnostic/treatment visit? Check appropriate box. This data item will be used as a check on false positive screening findings.
7. Follow-up care - Check one.
8. Does medical provider require assistance from worker, etc. - Check yes or no.

9. Diagnosis - This item is optional but would provide needed information on the results of screening and treatment. If more space is required, an additional sheet of paper should be attached.

10. Source of documentation - Check the type of source of information for this form. Examples of other sources are medical receptionist, medicaid office clerk, nurse, etc.

11. Reason for non-completion of referral-treatment process - Check appropriate box and explain reason that necessitates closure of services if appropriate. Check client unlocatable or no longer eligible if appropriate. NOTE: Item #11 does not apply if items 4 through 10 were completed.

12. DPW Worker/Agency Representative - Print name of person executing the form and DPW BJN.

    Signature - Worker or representative signs Form 402-S.

    Date - Enter date information was obtained.

# EPSDT CASE MONITORING SHEET

1. Patient's DPW number - enter number in spaces provided.
2. Referral number - enter the referral number that is pre-stamped on the corresponding 402. It is very important that the referral numbers are correct.
3. Case monitor code - enter in boxes.
4. Name - write patient's name in boxes, one letter per box.
5. Appointment record - This space is provided to assist the case monitor in following-up on client's treatment plan. The comments section should be used to indicate outcome of appointments made.
6. Narrative summary of follow-up - This space is to be used to record information concerning treatment received. Such information will assist in completing the following question (item #7). NOTE: Either #7 or #9 will be completed, but not both.
7. Problem status - to be filled in upon problem completion or 180 days from initial date of referral. Check appropriate box. NOTE: Item b is to be checked when the problem is cured or inactive, but more than one visit was necessary to achieve this status. Item c applies if treatment plan is terminated, but the condition cannot be considered cured or inactive.
8. Method of follow-up - Check appropriate box. If various methods were used in follow-up, indicate which method resulted in the most information.
9. Reasons for inability to complete problem - If treatment cannot be completed for non-medical reasons, check appropriate item.
10. Date form completed - enter date.
11. DPW worker signature - sign.

# Appendix 4

## Description of Software Configuration

# SOFTWARE CONFIGURATION

## I. Virtual Machine Facility

VM/370 release 3 is a control program that manages the resources of a single computer such that multiple computing systems appear to exist. VM/370 provides (1) virtual machines and virtual storage, (2) the ability to run multiple operating systems concurrently, (3) a conversational time sharing system - the conversational monitor system (CMS), and (4) a remote job entry manager, the remote spooling communications sub-system (RSCS). CMS provides, at a terminal, a full range of conversational capabilities: file creation and management; compilation, testing and execution of application programs. RSCS provides the remote user with the capability to automatically transfer files between: (A) VM/370 users and remote stations, (B) remote stations and other remote stations, (C) remote stations and a CMS batch virtual machine.

## II. Operating Systems

A. OS/VS1 Release 5.0A
B. CMS Release 3 (Conversational Monitor System)
C. RSCS Version 1.0 (Remote Spooling Communications Subsystem)

## III. Supporting Software (OS/VS1 Machines)

A. Batch Monitor (Local and Remote Job Entry):
JES/RES (Job Entry System/Remote Entry System)

B. Teleprocessing Monitor (Local and Remote):
CICS VS/Release 1.1.1 - High Level Language Processing
(Cobol and PL/1)

C. Student Oriented Batch (SOB) Compilers:
1. SPASM - Single Pass Assembler
2. WATFIV - Fortran Compiler
3. WATBOL - AND Cobol Compiler
4. PL/C - Student PL/1 Compiler
5. SCRIPT - Text Processor

## IV. Supporting Software (CMS)

A. Assembler
B. Basic
C. OS/VS Cobol Version 3.0
D. VS/APL (A Programming Language)
E. WATFIV Interactive Fortran
F. SPASM Single Pass Assembler
G. FORTRAN IBM's Fortran 'G' Compiler
H. PL1 IBM's Optimizing Compiler Version 1 Release 2.3
I. SORTF Fast Sort for CMS
J. CALC Desk Calculator for CMS

## V. Other Supporting Software

A. CVIS Computerized Vocational Information System
B. CTSS Classroom Teachers Support System
C. PSSP PL/1 Scientific Subroutine Package
D. FSSP Fortran Scientific Subroutine Package
E. OPTIC5 Test Scoring System, Used with OMR
F. ASMG Assembler 'G'
G. SPSS Statistical Package for the Social Sciences
H. BMD Biomedical Computer Programs
I. CW3 Coursewriter III - CAI Package

# EPSDT Demonstration Project

Dallas - 1976

Case Finding: Student Component

Prepared by
Nancy Barbas
Health Services Research Institute
(June 1976)

## ABSTRACT

Experimentation with undergraduate college students employed as case finders in an EPSDT program proved to be a cost-effective means of service delivery. The Dallas EPSDT Demonstration Project employed thirteen students recruited from local universities during the months of February, March and April, 1976. Representing the Department of Public Welfare, students made home visits to eligible clients, informed them of opportunities to obtain free physical examinations for family members under 21 years of age and appointed them to an EPSDT screening clinic. Students were paid three dollars for each client who they successfully appointed and who, as a result, received a medical screen at one of the several Department of Public Health screening clinics in the area. Evaluation of student casefinders was performed by analyzation of regularly kept data and client records and by field interviews with the program Director, Assistant Director, Student Supervisor in the Continuing Education Division and eight of the students. While several problems existed in the Project's use of students, they were structural in nature and not reflective of students abilities to perform. Recommendation is made that further exploration be made of students employed as casefinders in the EPSDT program.

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## OVERVIEW

A major goal of the Dallas EPSDT Demonstration Project is to experiment with new and original means of casefinding in the EPSDT program and to determine their cost-effectiveness. From February, 1976 thru April, 1976, student casefinders were used to represent the Department of Public Welfare and provide services to eligible clients in one sample sector of the research area. Students were recruited from local schools of higher education, acquainted with case-finding responsibilities and assigned a case load. Students were paid three dollars for each client who they successfully appointed and who as a result received a medical screen at one of the two Department of Public Health screening clinics in the area. The working hypotheses for this component were:

1. Students paid a $3 incentive fee for successful casefinding will result in higher client show rates at the screening clinics than standard methods of outreach.

2. The use of students paid an incentive fee for casefinding will result in lower costs per screen than standard methods of outreach.

Additional casefinders performing in the Demonstration Project area included Case Aides who were supervised by Project staff, high school educated indigenous to the area, College degreed Public Welfare Workers level I, and Welfare Service Technicians who were high school educated plus had two years college or equivalent experience, both of the latter two supervised by staff in the regional EPSDT program. Worker methodologies and size of work force varied between the different types of workers. Case Aides provide a broad basis for comparison with students though opportunities to compare Public Welfare Workers and Welfare Service Technicians are limited.

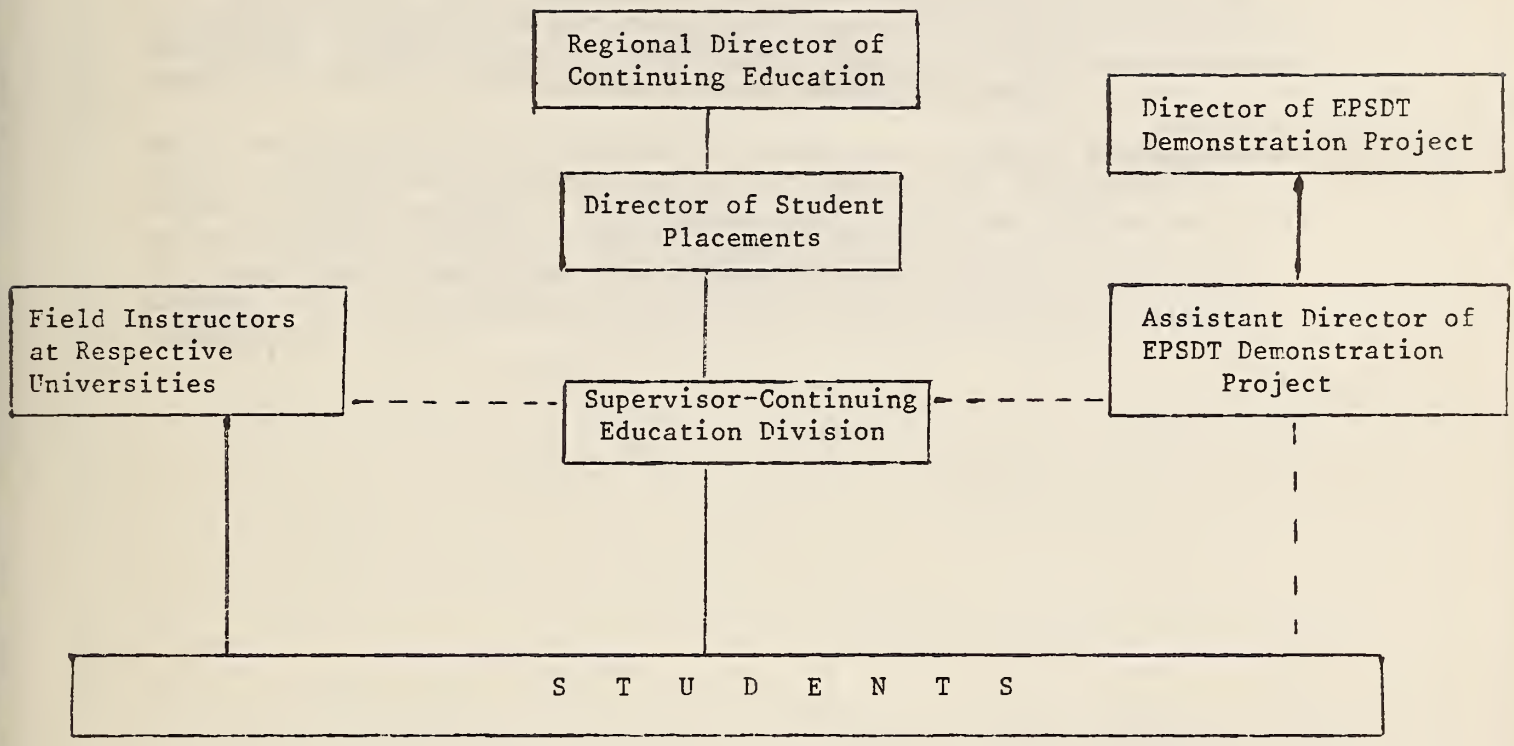
Further limitations which exist in the research are the shortness of time over which student activity was conducted resulting in a small absolute amount of activity to measure, and the component's occurrence during the first operational months of the project, a time before data collection techniques and project administration were fully mature. Also, certain elements considered to be essential in the delivery of EPSDT services such as client transportation and up to date lists of eligibles, were not available to student casefinders nor the Case Aides. For these reasons the performance of Students and Aides reported here may not be typical of their performances under more optimal conditions. Reports of the success of the students, though, are substantiated by their comparison with the Case Aides who worked under the same operational setting and performance restrictions.

## STRUCTURE

The responsibility for implementing the student component was assigned by the Director of the Demonstration Project to the Assistant Director. The Assistant Director served as the planner, interdepartmental coordinator and student supervisor in the student component. Due to late alteration of the Demonstration Project design, planning for the student component was limited to approximately one month. It was learned early in the planning process that regional DPW policy dictates that students receiving field placement credit for work performed at DPW must be affiliated with the Continuing Education Division and assigned a supervisor within that division. Furthermore, students earning credits are assigned a field instructor, a staff member of the school they attend, who oversees their out-of-classroom activities. The Continuing Education supervisor and the field instructors are external to the EPSDT Demonstration Project. In an attempt to bypass these extra-departmental affiliates, the system of recruiting students from schools without offering them opportunity to earn educational credit was discussed. Recruitment efforts were conducted without success due to the limited amount of time available to perform this task and to the late date during the colleges' semesters which was a time in which students schedules and arrangements for field placements were already established in most cases. So an agreement was made with the Program Director of Continuing Education to 'share' with the demonstration project students recruited through that division. The Continuing Education Program Director established guidelines for the assignment of students specifying that they would be assigned to a supervisor specializing in Family Services within the Continuing Education Division and that each student would be available to the EPSDT Demonstration Project eight hours per month with the exception of one student who was serving a second term of placement with the department and was assigned a full time placement with the Project. Therefore, with one exception, student responsibilities remained predominately in working with Family Services Clients assigned to them through the Continuing Education Division and were only marginal in the EPSDT project, participating in the project generally about one-eighth of their assigned field work time. The agreement was planned for the duration of one school semester, approximately fifteen weeks. The chart on the following page delineates the inter-departmental alignment and lines of supervision.

The EPSDT Demonstration Project Assistant Director established the internal operation of the student component. She assured that students operated under the established research methodology (i.e. performed outreach through personal contacts with clients). Also, she assured that student activity was confined to the established research area and population sample.

STUDENT COMPONENT
ORGANIZATIONAL CHART




——— Direct supervision including evaluation responsibilities

------- Coordination and/or support supervision

## GOALS

The student componant was aimed at increasing utilization by eligibles of the EPSDT screening program. An objective defining what percentage of clients utilizing the services would be considered successful was not specified. Rather, plans for comparisons with other research componants designed to measure performance in case finding were made.

While the major goal was provision of services to clients, a minor goal was to increase the knowledge and capabilities of the students in a client outreach capacity. This second goal evolved due the demonstration project's close affiliation with the Continuing Education Division of the Department of Public Welfare through which the students were recruited. This second goal proved to be the major goal of the students themselves.

## PROGRAM OPERATION

### STAFF

1. Profile

Thirteen undergraduate students participated in the student component with sole responsibility for casefinding. All of the students were specializing in social science studies, i.e. social work, rehabilitation, sociology. The students were earning school credit for their activities in the EPSDT project. The schools attended by students were:

Southwest Medical School of Allied Health Science
Southern Methodist University
Richland College
North Texas State University
Texas Woman's University
University of Texas at Arlington

Eleven students were female and two male. Students received no direct payment for their work but were awarded $3.00 for each eligible client who they appointed and who as a result received screening services. All students provided services under a written contract agreement according to Department of Public Welfare policy. Money accrued through their earned incentive payment was distributed after completion of the semester. Financing was administered by means of a purchase voucher submitted by the Project Assistant Director to the State Department of Public Welfare.

2. Participation

Nine students were active in the program during February, March, and April. The one student serving full time placement at the project was scheduled to work a total of 192 hours during the months of February, March and April. The additional twelve students were each scheduled to work on the average about 25 hours. Their range of assigned time was from 20 to 34.5 hours each. In total, all thirteen students were scheduled to participate in the EPSDT program 492 hours over the three months. It is interesting to note that this is equal to the hours worked by one full time employee over a 12.3 week period or the approximate duration of the student component. A policy of the Continuing Education Division states that students are required to make-up field placement absences. Even so, students accumulated a large number of absences from the EPSDT program that were not made up. Hours actually worked by each student were recorded weekly on an Individual Work Sheet completed either by the students themselves or (if they did not have time or forget to do so) by the Assistant Director. These records reflect a total of 248 hours worked by students or less than half that for which they were scheduled. Approximately 100 hours of absence were accumulated by the full time student due to illness for which she was hospitalized in Mid April thereby discontinuing field work. Two other students were particularly prone to absence due to difficulty in acquiring transportation.

3. Training

Participation in the EPSDT program was precipitated by attendance at a one-day seminar conducted at the Continuing Education offices by the Assistant Director of the EPSDT Demonstration Project. The training seminar consisted of:

- an overview of the demonstration project in which the Assistant Director, using visual aides, discussed the services available to clients, the research project client population and geographic area and additional experimental variables under study.
- a brief introduction to other Department of Public Welfare services with program pamphlets available to trainees.
- a role playing exercise
- brief instructions on two project forms used by casefinders, specifically the Individual Work Sheet and the Family Contact Form.

Two students were absent at the training seminar. An orientation visit to one of the screening clinics was also planned, but due to lack of advance notification, and to students varying school schedules, only two students were able to attend, accompained by the Assistant Director. Also, several students participated for a half day each in the late January training that was conducted for full time demonstration project staff.

CLIENT TARGET

The EPSDT program provides services to persons age 0-21 eligible for Medicaid. Students were assigned to make outreach attempts to clients who met the following description:

- resided in one of the Dallas area zip codes, 75208, 75216, 75203, or 75224.
- had a family name (Medicaid Payee) which began with one of the letters of the alphabet K thru Z.
- had an assigned Medicaid number with a last digit of 5 or 9.

The population of clients served by the students totaled approximately 750 who were predominately of the Black race. This number represents approximately one-tenth of the eligible population in the designated zip codes.

SERVICE DELIVERY SYSTEM

1. Definition of Services

Students were responsible for introducing clients to three types of services in the EPSDT Program.

- informing clients of and appointing clients to Medical screening clinics
- informing clients of and initiating authorization for dental care services.
- informing clients of family planning services.

2. System Management

The Assistant Director of the EPSDT Demonstration Project organized and supervised all management phases of the student componant. Management activities included:

- coordination efforts between the project and the Continuing Education Division. These consisted mainly in planning activities as discussed in the section on structure.
- training
- interpreting methods requirements to students to assure conformity to research techniques
- designing monthly work assignment schedules for students
- assuring students received an adequate caseload
- supplying students with letters, forms and pamphlets needed to perform.
- providing technical assistance to students
- performing fill-in activities during student's absence or to supplement student's time
- obtaining and distributing earned payment

Student evaluation was the responsibility of the Continuing Education Supervisor and the school's field work instructors. The Assistant Director had little, if any, input into evaluation of the students, even in their EPSDT work performance with the exception of the one full time student.

3. System Capacity and Utilization

As mentioned earlier, students were scheduled to work a total of 492 hours. This is equivalent to about 62 full days of work applying the Department of Public Welfare's definition of an eight hour work day. The Assistant Director estimated that casefinding could be performed for 7 clients per one work day. Student reports of the number of clients they attempted to visit per day concurred. Multiplying the number of clients seen per day, times the days scheduled, it can be seen that the total capacity of the student componant during its duration was about 430 client families.

Various factors contributed to the actuality that much less than 430 client families were assigned to student caseloads or attempts made to perform casefinding techniques with them. The explanations include:

- Student absences greatly reduced hours actually worked.
- Several work days were devoted to additional instruction and supervision rather than client contact.
- Several repeat contacts with a single client family reduced time available to contact new families.
- Portions of several work days were devoted to office paper work rather than new client contact.

A total of 159 client families were assigned to students and some kind of attempt made to perform outreach for them.* Among these cases there were ten client families who were assigned to students who, it was learned after assignment, moved outside of the designated target area or became ineligible. Time was spent by students in attempting to contact these clients which resulted in establishing their status of ineligibility. An examination of the capacity of the student component minus accumulated absences (248 hours or 31 days) and the number of assigned cases for which attempted outreach efforts were made (159 cases) determines that attempts at client contact averaged out to 5.2 families per day. Thus, a realistic estimate of the number of families per day for which a student can complete home visits, complete all required record keeping, and additionally can receive necessary supervisory assistance, is 5.2.

4. Worker Modalities

The students shared one office provided for them at the EPSDT Project. When at placement, it was rarely necessary for more than three students to use the office at a time.

The following page contains a diagram of student's treatment of cases. A detailed description of procedures and techniques used by students is broken down here into stages which correspond with the diagram.

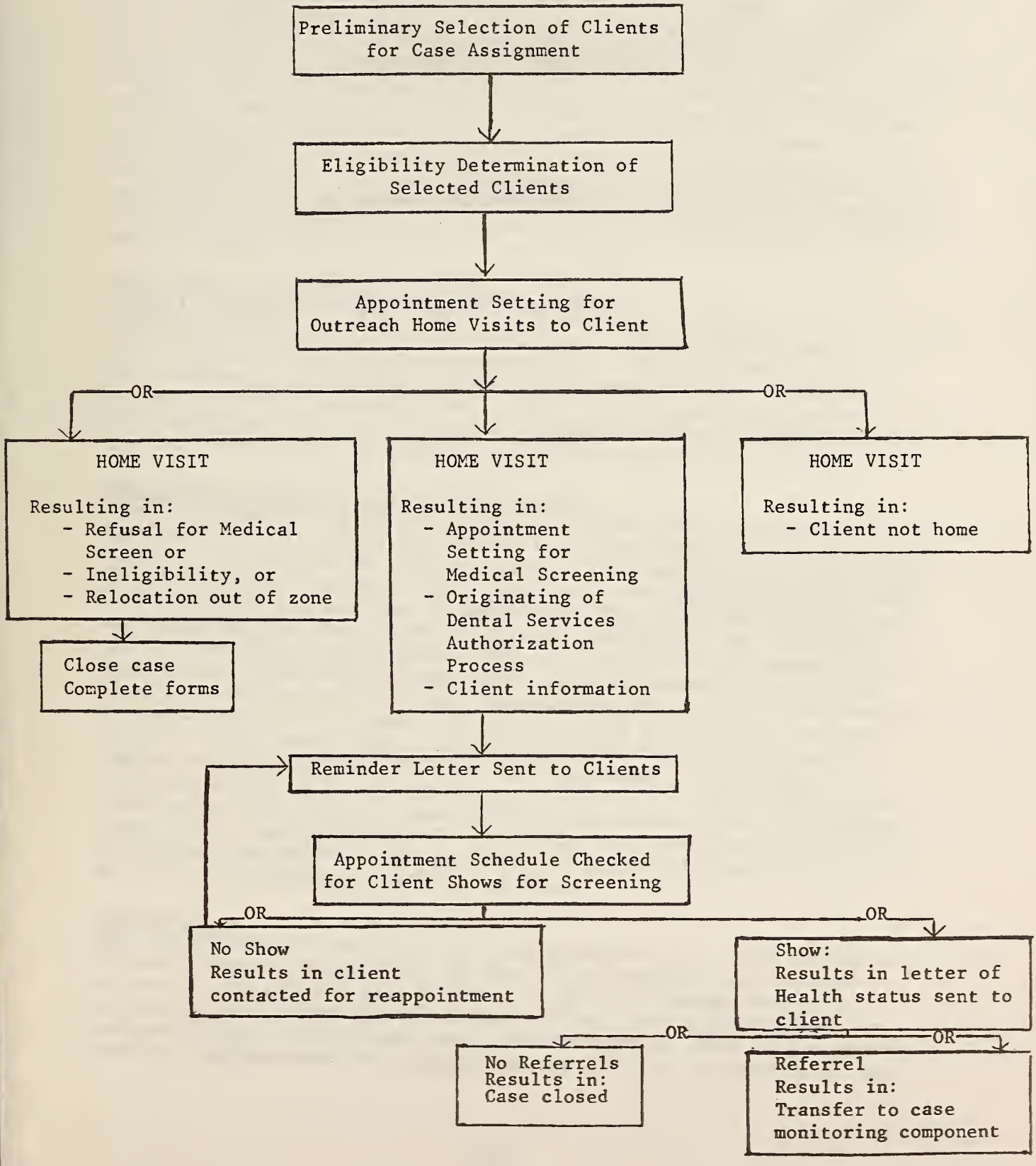
Preliminary Selection of Clients for Case Assignment

During the first several weeks of the student component the activities were, so to speak, gotten off the ground, by the Assistant Director's assignment of cases to the students. As students were broken in, though, they performed their own selection of clients. They were provided with the Department of Public Welfare's list of Medicaid eligible clients (Form 708) and were instructed to chose sample cases only (as defined in Client Target) and to verify that the client was due for a screen from information available on the 708. One student reported that it was difficult to determine who was due for a screen according to the 708. This was difficult for students because the 708 is not always up to date.

*This data is derived from a report by the case records technician in charge of controlling all case folders assigned to project staff. It may differ slightly from data accumulated by the Family Contact Form.

Casefinding - Student Component

Flow of Case Procedures



The students worked from only one zip code area at a time and as clients were depleted were supplied with information on a new area. In addition to the established criteria for selecting clients, students employed some personnel selection basis. A majority of students attempted to chose families on the basis of size, feeling that a large number of children afforded them more opportunity to earn incentive payments. Two students mentioned that selection was based on location of residence in addition to family size in an attempt to make travel to home visits more ordered and efficient. Also, some students used the cirteria of whether a client had previously been screened in earlier years - one student suggesting she preferred previously screened clients due to the belief that it was easier to explain the program to them and several other students preferring those never screened feeling they were more in need.

Eligibility Determination of Selected Clients

Students confirmed eligibility of clients by telephoning to a central Department of Public Welfare check-out point (telecommunications). This step was bypassed by the students in a number of circumstances, for instance if the Assistant Director had made the case assignment herself or in the instance of one student inparticular, when making the assumption that the assistant director would check eligibility after she received the list of selections from the student.

Appointment Setting for Outreach Home Visit

After compiling an appropriate number of clients for a single day's caseload, students filled out introductory appointment letters, personally signed, to be sent to the clients. The letter (See Appendix I) informed the client that a Department of Public Welfare representative would visit on a specified date and time to inform her of an important health program and requested that she be home or call to reschedule a more convenient time. Approximately four appointments were scheduled per one-half day, a half hour to three-fourths hour apart. Students prepared the letters, usually at the end of a work day, scheduling appointments for the next day of assignment in the program. The letters were given to the Assistant Director with a carbon copy - the original sent to the client and the carbon used as a tool for the students when making their visits. In a few instances clients were visited at different times than scheduled because students neglected to make carbons and had on record of appointed times. Also, sometimes students would make home visits without sending an advance appointment letter possibly due to lack of time or to an unforseen rearrangement in field work days.

Home Visit

Students were required to have their own transportation for making visits to clients. Several students did not have a car available and arranged to work on the same day with another who did have transportation, so travelling in a threesome while making visits. They each had their own assigned clients and conducted each visit privately. Most of the students were not familiar with the geography of the area and expressed that they

had a good deal of difficulty and spent a lot of time finding addresses. This problem existed in spite of the Assistant Directors frequent advice on directions and provisions of a map.

Students experienced varying degrees of success in finding clients home when they arrived. Students reported that they actually had an opportunity to speak with clients in one-tenth to three-quarters of the cases they visited. Two of the students who had particularly bad luck in finding clients at home had these reactions to the problem - felt a permanent worker with more time to "hustle" would be more worthwhile in the program than students with such limited time; felt that sending letters sometimes encourages people to leave their home and it might prove better to surprise them; when working with scheduled appointments there is a problem of getting ahead or behind time which may relate to people not being home and may, if the worker wants to get back on schedule, waste much time; felt a phone call in addition to a letter would be useful for visit scheduling and that an explanation that the visit scheduling has no relation to recipient status would help. Students were instructed to reschedule home visits when they were unable to speak with the client. One student said that she made these repeat attempts approximately five times. Her technique was to send the lead letter with an extra explanation saying that she attempted to visit once before without luck and to please "save her the trouble again" by phoning her to inform her if the time was inconvenient. This technique proved very effective with this student never making a second visit unseccessfully. This student also questioned clients as to their absence at the first scheduled visit and received such explanations as - ' works part-time', and 'was asleep'. Several other students stated that it was impossible, due to lack of time and somewhat to lack of organization, to follow through on cases not at home on the first visit. Only two of the eight students interviewed said they had ever done so. One student said that she was not even aware that follow-up was part of the assignment and that it would be impossible anyway. Over forty client cases were left in on open status, one unsuccessful visit with no follow-up by the end of the placement period.

Students treated clients with different techniques when finding them home and available on home visits. Students reported spending from "less than five minutes" to as much as one-half hour with clients. Informing the client of the availability of a medical screen for each child and of dental services took place in all instances. Family Planning was sometimes discussed, seemingly to depend on the students reaction to the specific client. Following is an accumulated list of items of discussion used by students, though each student used his/her own style and was more or less conversant.

- introduction of self giving name and identification with the Welfare Department, and possibly relating student status. (Some students believed that claiming student identity made the clients more sympathetic to their efforts).

- questions as to whether children have received a physical examination lately either from a doctor or screening program.
- sells the medical screening giving encouragement such as - it's free, it's important, it takes only a short amount of time, it has preventive benefits, and even, it saves the welfare department money.
- if client is interested, requests correct spelling of names and age of children, requests use of phone to call for appointment, leaves reminder note with time and location of screening appointment, gives directions to clinic and discusses transportation arrangement. (Students do not offer transportation to the clinic themselves).
- May discuss and inform clients of other departmental services.

Finally, when a home visit is made and the student establishes at that time that the client refuses services, is not eligible contrary to the eligibility list (states has 'gone off welfare'), was screened last month, has moved, or the address is not locatable, the case will be closed.

Reminder Letter Sent to Client

Clients who request an appointment for medical screening are sent a reminder letter which is filled out by the student and mailed by the Assistant Director. Students reported that they follow this procedure most, though not all, of the time.

Appointment Schedule Checked for Client Shows

Records of appointed clients are kept in suspense by the Assistant Director until after the appointed day. Clinic appointment schedules on which attendance has been recorded are available to the students. A varying situation existed in which some students actually checked on their successful appointments and completed forms accordingly, some never attended to client shows. The Assistant Director formally checked the schedule and performed the recording. Instructions were given that students were to perform follow-up activities for clients who did not show for screen. When interviewed, two students specifically stated this was not an assigned responsibility and several students noted there was definitely not enough time for them to perform follow-up. Only two students said they actually did make a second contact with a client by phone or in person to find out why the client didn't attend the clinic and to re-appoint for another screening. At the conclusion of the student componant, twenty-five cases were 'open' - or ones for which a first clinic appointment was missed and no follow-up for reappointing yet performed.

Letter of Health Status Sent to Screened Clients

After a client has received screening services, the Assistant Director received health records along with any referrels from the health screening team. In those instances which the child was reported to be in good health, a copy of the health record and letter of closure was sent to the client. (See Appendix I) This function was performed by the students for only about one-quarter of the cases, the Assistant Director or clerk assistant filling in for the rest. In instances for which further diagnosis or treatment was indicated, the case record was transferred to the case monitoring subsystem and assigned to a new follow-up worker.

Case Closure

A case is closed in the casefinding subsystem if:

- client refuses services.
- client is determined to be ineligible.
- client moves or is not locatable.
- client successfully completes screening with/or without referrel.
- client does not complete screening after three appointments scheduled or after 90 days from first contact have passed.

At the occurrence of any of these instances the students were to complete all management and data collection forms and appropriately turn them in to the Assistant Director or file them in the client's case record. Recorded on the management form (See Appendix - EPSDT and Family Planning Recording Sheet) are all of the services which the student delivered to a client. Filing of these management forms and copies of client correspondence, and filing and distribution of the data collection forms was often performed by the Assistant Director and a clerk assistant rather than by a student. A client folder, upon case completion was to contain a copy of an EPSDT and Family Planning Recording Sheet, copies of all appointment letters and other correspondence, a copy of the health record, and a copy of the Family Contact Form.

Utilization of Support Services and referrels were reported by approximately half of the students. They stated that they made use of pamphlets with information about other social/health services that were provided them for the clients. Among the topics and programs discussed in these pamphlets were Immunizations by the Health Department, Sickle Cell Anemia, Dental Care, Planned Parenthood, Venereal Diseases, Work Incentive Program. (See Appendix)

Three students reported that they made direct referrels into other Department of Public Welfare Programs. A direct referrel constituted reporting a problem on client situation called to a student's attention during an EPSDT home visit to the Continuing Education Supervisor who subsequently instructed the student or contacted the appropriate referrel source herself.

Because students could not provide transportation themselves, the public transportation services were an informal support service. Most students reported that they felt or that client's indicated that transportation to the clinic was not a problem. Several students did make an attempt to acquaint clients with bus services, but were unfamiliar with routes and schedules in the target area themselves and had to rely largely on directing the client to the phone number of the bus service to obtain the necessary instructions.

CLIENT PARTICIPATION RESULTING FROM
STUDENT PERFORMANCE

Following is a chart which delineates client participation in three medical screening clinics, A. Harris, Lion's Club, and Martin Luther King through student outreach efforts.* Note that the King Clinic is geographically located outside the Student Component Sector.

TABLE I

Monthly Client Participation
Resulting from Student Casefinding

| Month | Number of Families Willing to Participate | Number of Children Scheduled | | Number of Children Screened |
|---|---|---|---|---|
| | | A. Harris Lion's Club Clinics | King Clinic | |
| February | 6 | 11 | 2 | 8 |
| March | 16 | 61 | 17 | 33 |
| April | 39 | 85** | 6 | 23 |
| 3 month total | 61 | 157** | 25 | 64 |

Individual students scheduled within a range from zero to forty-two clients for screening appointments which resulted in from zero to twenty clients successfully screened. Individual student performance was dependant on a large number of variables among them the number of hours actually worked, client absences at original home visits for appointment setting, different educational and experiential backgrounds of students, and varying client characteristics. The number of cases assigned to individual students is too small to draw valid conclusions as to preferred characteristics in student casefinders.

* Data derived from Appointment Schedule
** Includes two children scheduled in clinic of May 6.

## DATA COLLECTION/RECORD KEEPING

Essentially three types of records were kept in the student component. First, an account of cases assigned per student was kept by use of a Case Assignment and Case Activity Sheet. Students entered the names of their clients on their own sheet which, in turn, was used as a management tool by both them and the Assistant Director. This information was filed specific to each student.

Second, information specific to a client was recorded. All correspondence between the client and student concerning EPSDT or Family Planning was filed in carbon in the client's record. Also, an EPSDT and Family Recording Sheet was kept up to date according to the services delivered to the client and filed in the records. These records were critical to the continuity of treatment given the clients. Individual case records had been transferred from the on-going program and organized in a special student component file, by a record's technician. As pre-arranged, at the conclusion of the student component, these records were returned to the program at which time it was essential for accounts to be available informing the on-going workers of service efforts performed by students for an individual client.

The third type of records kept were for data collection and evaluation purposes as designated by the project evaluators.

Often the completion of records was delayed, in many cases until the end of the component, due to the built-in need for suspense records pending client's activities and due to the limited amount of time each student was available for participation in the program. Often the Assistant Director took over recording and filing activities but was dependent on student input in some cases which was not always convenient to obtain.

Copies of all forms can be found in Appendix II.

## DISCUSSION

### STUDENT PERFORMANCE

The monthly development of the student component resulted in observable trends in activity. During the month of February students reported working a total of fifty-six hours. Actual casefinding activities were not begun until February ninth. A total of thirteen children were scheduled to be screened in Feburary in most instances as a result of efforts in February.

In March, students worked 108 hours, an increase of 93% over the time worked in February. Seventy-eight children were scheduled to be screened in March, an increase of 500% over the previous month.

April reflected a decrease of 22% in hours worked below March with a total of eighty-four. The number of children scheduled for screening, in general through efforts in April totalled 91, and increase of more than 16% over March efforts.

TABLE II

Trends in Hours Worked *

| Month | Number of Hours Worked | Percent of Increase |
|---|---|---|
| February | 56 | |
| March | 108 | 93% |
| April | 84 | -22% |

TABLE III

Trends in Scheduled Appointments **

| Month | Number of Clinic Dates ***A. Harris, Lion's Club, King | Number of Clients Scheduled | Percent of Increase |
|---|---|---|---|
| February | 4 | 13 | |
| March | 10 | 78 | 500% |
| April | 7 | 89 | 16.66% |

* Derived from Individual Work Sheets

** Derived from Clinic Appointment Schedules

*** The number of appointments per clinic available for students' clients was never a constraint on students performance. Therefore, increase of clinics is not a factor in increase of clients scheduled.

For both March and April, the increase in appointments scheduled over the previous month was larger than the increase in hours worked by students. A plausible explanation for this more successful use of time (assuming that all hours worked were utilized in a similar manner, for home visits) is increased expertise of students in this phase of case finding over time and a demonstration of breaking into the system. This explanation is also substantiated by several students comments that they were most tense and less confident on their first home visits.

Another trend in contrast to the number of appointments scheduled by students was the students' client show rate each month. The show rate, or porportion of successful appointments to unkept appointments equals

$$\frac{\text{\# of children screened}}{\text{\# of children appointed.}}$$

The student show rates reflect a decrease in success each month from 61.54% in February to 42.30% in March to 25.84% in April. Similar trends can be observed over the three months in the efforts of the other types of casefinders who schedule clients into the same clinics as the students. (See Table IV). Students, Case Aides and Public Welfare Worker I's all were subject to a slack period in April. The show rates examined here do not reflect the differences between types of casefinders in over all number of clients schedules due to unequal work forces. Also, all four categories of workers experienced fluctuations in number of workers and worker time availability over the three months.

TABLE IV
Trends in Client Shows for Screen
by Type of Worker*

| Worker Type: | Student | Case Aides | Welfare Service Technicians | Public Welfare Worker I |
|---|---|---|---|---|
| Month: | | | | |
| February | 61.54 (N=13) | 42.68 (N=82) | 38.89 (N=244) | 41.39 (N=36) |
| March | 42.30(N=78) | 42.21 (N=308) | 46.13 (N=201) | 51.74 (N=323) |
| April | 25.84 (N=89) | 19.05 (N=147) | 43.39 (N=92) | 23.91 (N=189) |

The show rate can be further examined as an indication of successful performance. Comparison between students and Case Aides demonstrates a striking similarity in performance according to Table V. Case Aides differed from the students in their educational experience, with Aides possessing high school degrees and the students having earned at least

* Derived from Clinic Appointment Schedules

sixty additional hours of college credit. Furthermore, the status of Aides as full time salaried staff members is an interesting contrast to students part time status and possibly a factor neutralizing the effects of less education. Though the available work force differed betweem those two types of workers, there being three full time Aides in February and March and two in April, it is important to note that they performed identical case finding responsibilities, used the same face-to-face method of client contact, both began their EPSDT casefinding responsibilities in February and worked under the same constraints, i.e. no formal transportation available nor worker transporting of clients to clinics allowed. (No comparison of success is made here with Welfare Service Technicians or Public Welfare Workers due to the variations that existed between them and students and aides on all five variables mentioned above).

TABLE V

Comparison of Show Rates by Worker Type
(February thru April, 1976)

| Worker Type: | Students | Case Aides |
|---|---|---|
| Number of Clients Scheduled | 180 | 537 |
| Number of Clients Screened | 64 | 193 |
| Show Rate | 35.55% | 35.94% |

A major discrepancy between the idealized system planned for the student component and the actual performance, occurred in follow-up activities. The two major explanations for lack of performance in this area are insufficient time and unclear training .

Students were questioned as to whether the amount of time they were assigned to the EPSDT project was adequate to meet the level of performance they desired, i.e. did they feel they were able to successfully deliver services as well as acquire knowledge.

Half of the students interviewed stated they would have like a larger amount of time assigned to the EPSDT project. They felt more time would allow them to both contact a larger volume of clients as well as allowing them to get more involved with individual clients to make a more substantial effort with each rather than the hit and miss effort that existed. As it was, the limited time prohibited the students opportunity to carry out all phases of casefinding and led to the feeling of disorganization. Students said it was helpful to have concurrent assignment with Family Services. The expertise acquired in each program lent itself very well to the other. Also, it provided a wider base of learning which students

said they preferred to a very in-depth experience in one or the other. Several students suggested that a more even division of time betweem the programs would have been beneficial. It appeared that not only the amount of time but the organization of that time was detrimental in some ways. Students stated that it was difficult to remember procedures and further develop techniques when participating in casefinding only once or twice per month. One student suggested that in the event of a 'split' field placement in the future, division by blocks of time, for instance spending two weeks straight with EPSDT, would be more productive. The Assistant Director, too emphasized a need for students to be assigned more time with the project to improve their performance. The recommendation was made by the Assistant that students placements should be full time in one program rather than split between two. This would allow for students to participate in the program two days per week during the semester and would allow for students to perform in all phases of casefinding-case assignment, home visits, follow-up visits, records completion-many of which it was necessary for the Assistant Director to complete herself. In redesigning the system, the Assistant Director stated she would assign ten students two days each per week, the equivalent of four full time staff.

Students made several responses in regard to adequacy of training and supervision in the EPSDT project. Suggestions for improving the training were: Provide opportunity for visit to a clinic, provide opportunity for observing or accompanying full time casefinder, and provide clearer and more complete instructions on forms, as a number of forms were not discussed at all at training. One student noted that the role playing was not beneficial as it was a classroom activity which she had participated in many times before. A number of students felt supervision at the project site was insufficient due to the Assistant Directors unavailability. Also, students noted that peer interaction and assistance occurred commonly and was very helpful leading to the suggestion that group seminars may provide good learning experience.

Pertaining to the supervision, the Assistant Director added that a source of the problem experienced in her availability to students was the large number of assignments in the project which she was responsible for in a addition to the student component. The suggestion was made that this type of program should be designed to assign one staff member with a major responsibility and large portion of time to students. Also, in administrative arrangement designed to give the supervisor direct authority over evaluation of students would provide greater contacts on student performance for instance in the area of absences.

All students felt they were able to gain experiential knowledge through this field placement. A goal of all students interviewed was to learn about several different facets of the Department of Public Welfare. All felt they had achieved this through their joint placement in EPSDT and Family Services. Many students did acknowledge, though, that they had very little, if no, interaction with EPSDT project staff but were not unsatisfied with this limitation. (The one exception is the student who felt interaction with a project casefinder in regard to training would be helpful). A second goal which students expressed having, was to acquire a profile of participating clients and to improve skills in

client contacts. Aside from the exceptions of students whose assigned cases were all absent at the time of the visit, the students felt this was the most fulfilling part of their placement with the EPSDT project. An observation made by the Director of the EPSDT project was that students 'had a feeling of importance' as a result of their direct contact with clients and that students working in this capacity seemed very appropriate. It was also felt that students from other disciplines beyond the social sciences could benefit from this type of field placement and work well in this arrangement.

Students expressed very positive reactions to the services available to clients in the EPSDT program. One student did express the incite that she felt there would be less complication to the client if there was a single system of appointment setting and actual screening so that clients had the opportunity to make their own arrangements with the clinic rather than being routed through an outside worker, in this case the Department of Public Welfare Worker.

COSTS

The direct cost of conducting casefinding through a student component included supervision and training (time devoted by the Assistant Director), the accumulated incentive reimbursements earned by students, and a small amount of clerical assistance.

The Assistant Director reported spending a total of 43 hours in student supervision over the twelve week period and four additional hours conducting training. (Note that this does not include planning time). Based on a salary of $1300 per month, costs can be pro-rated equalling a total of $382.34 for supervisory costs.

Reimbursement incentives paid at a rate of 3.00 per show for screen came to a total of $192. Students reimbursement payments ranged from $0 to $60. The students regarded this reimbursement as a small circumstantial bonus but felt that it did not increase their motivation in the field placement above that which they would ordinarily have had. They indicated that reimbursement for travel expenses incurred through the placement would been financially more helpful and of greater assistance for performance in client outreach. In fact, the three dollar per screen reimbursement was a negligible reward when considering students' enrollment fees at a university. Students major earnings were course credits. Participation in the EPSDT student component for field credit was dependant on student's proclivity for transportation, thus credit earnings and travel reimbursement are strongly linked. The cost of a travel reimbursement method of payment can be computed for the student component equal to $74.40. This is an estimate based on $.16 per mile, currently the travel payment policy of the Department of Public Welfare, times 15 miles per field work day, the Assistant Director's approximation of student travel on client visits.* Travel expenses pro-rated according to the demonstrated number of successful screens (64) for 31 days of student work can be seen in Table VI.

* Based additionally on travel records of Case Aides performing the same function in an adjacent geographic area. Aides daily travel = 25 miles/day minus 10 miles to and from target area not applicable to students = 15 miles

TABLE VI

Casefinding Cost by Method of Reimbursement

| Method: | Established Payment for Successful Screen | Established Payment Plus Travel Reimbursement | Travel Reimbursement only |
|---|---|---|---|
| Per Screen | $ 3.00 | $ 4.16 | $ 1.16 |
| Total Student component 3 months | $192.00 | $266.40 | $74.40 |

Brief comparisons with Case Aides and Public Welfare Workers salary costs can be made by reducing their respective salaries of $552 and $795 to the equivalent hourly wages. The hourly of salary paid to a Case Aide is $3.29, and the total amount for 248 hours of work equals $814.86. A Public Welfare Worker I's hourly wages equal $4.73 or $1173.57 for 248 hours. Both figures dramatically demonstrate the higher cost of employing salaried personnel in the same casefinding capacity as the students were used but are irrespective of performance.

Taking performance into consideration, the following table demonstrates salary costs per screen of the Case Aides and student casefinders. Computation is based on monthly salaries paid to three Case Aides during February and March and paid to two Case Aides during April ($4,416 ) divided by the number of successful screens appointed by the Aides over the three months (193)*. Overhead, supervision and clerical assistance is not included in these figures. (Again, no comparision is made with Welfare Service Technicians or Public Welfare Workers due to large differences between them and Students).

TABLE VII

Cost per Screen by Type of Worker
(February thru April, 1976)

| Students | Case Aides |
|---|---|
| $3.00 | $22.88 |

* Though salary was paid to all three Aides in April as in the first two months, one Aide was absent on pregnancy leave. The unusual circumstances of this lengthy paid unproductive time warrants subtraction from productive paid time in order to avoid gross distortion of costs.

## CONCLUSION

The student component has been a successful demonstration of a cost-effective means for performing casefinding in the EPSDT program. Student performance resulted in similar show rates for clients scheduled at clinics as full-time salaried Case Aides' performances. Furthermore, monetary reimbursement paid to students in this component was far less per screen than payment per screen to Case Aides. Also, an hypothesized expense figure for payment of students by travel reimbursement proved to be much lower than total costs paid to salaried staff, but would be dependant in an individual program on travel policies and geographic location of target population. Employment of students enables a program flexibility in the decision of the method and amount of financial expenditures spent on student employment and may be varied according to an individual program's assets and policies. Since monetary reimbursement is only a part of the payment students expect to receive for their efforts, a trade-off between that and education credit, supervised experience and knowledge can take place.

While students proved successful as casefinders, one major area of failure experienced in the component was the low absolute number of clients outreached as compared to full time staff. This can be attributed to an inadequate student work force and to the high degree of absenteeism occurring among that work force. A second problem area occurred in the lack of follow through activities that took place, again attributed to inadequate time available for students to perform.

The Assistant Director and Project Director both feel that the above inadequacies were the result of problems in planning and structure and not a comment on students capabilities as casefinders. Replication of a student component such as this one is recommended for an EPSDT program with the following changes in structure and planning:

- administration of the student component should be handled directly through the EPSDT program rather than through an extra-departmental program or organization such as the Continuing Education Division.
- Supervisory and evaluation responsibilities should be placed within the jurisdiction of the program that is the direct employer of the students.
- written committment should be attained from participating universities that all possible attempts will be made to provide an agreed upon volume of students for the duration of one year, thus assuring the program necessary manpower though the constituents may change each semester.
- time assigned to field work in the program should be no less than two days per week for each student
- interviews should be a part of the student assignment process enabling students to discuss whether participation in the EPSDT program will satisfy their interests in learning and providing the program with some selectivity.

Additional suggestions, the plausibility of which would depend on each EPSDT program are:

- Assign a salaried staff supervisor full time responsibility for coordinating and supervising students.
- Recruit students from schools of higher education located within, or in close proximity to the geographic area served by the program.
- Assure transportation is available for students making home visits by requiring they have their own mobility or by supplying them with the use of a program vehicle.
- Contract with training advancement programs such as Rehabilitation Commissions or Work Incentive Programs to enroll students in the EPSDT program for on-site training in return.

The above suggestions apply to the employment of students as casefinders in the configuration demonstrated in this project but could additionally be applied to the planning and administration of students working in another configuration of casefinding. Though the students demonstrated equivalent rates of performance as Case Aides, their performance with regard to other types of workers or methods of casefinding was not substantiated. A previous report of the Health Services Research Institute states that when the object of outreach in EPSDT program is more than simple informing of clients, Case Aides performing home visits who, additionally, can offer transportation opportunity to clients to clinics are most effective.* This poses the question of how would students perform within a program which could assure transportation to clinics for clients in need. Or, though students performed favorably compared to Case Aides by making home visits to an eligible, how might they perform using other methods.

The possibility for further improvement in casefinding through a student component exists by taking advantage of the special talents students may have and of the commonalities they may share with a select group of eligibles. Specifically, outreach could be conducted by students directed toward the adolescent client, through speaking engagements at public schools, through coordination with youth clubs, through formation of EPSDT program affiliated teen health councils. Schools offer a particularly conducive setting for student workers to perform in - college undergraduate students often being only slightly older than the adolescent aged eligibles as well as sharing the status of school enrollment. Furthermore, the increased prevalance of health education courses in public schools lends itself to inclusion of the EPSDT program as a part of the preventive health care subject matter.

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* EPSDT Demonstration Projects Evaluation Report (An Interim Report, April 1, 1, 1974-March 1975; Health Services Research Institute; University of Texas Health Science Center at San Antonio.

The Dallas EPSDT Demonstraiton Project has designed a research variable to measure a Young Adult Clinic as an indirect motivation for participation in the EPSDT program by adolescents. Experimentation with direct intervention by student casefinders performing outreach in schools, and youth clubs merits serious consideration. Employment of students who work with schools and clubs may demonstrate an appropriate and cost-effective means of involving the older client in EPSDT.